RESEARCH

BEING A NURSE IN THE FAMILY HEALTH STRATEGY PROGRAMME: CHALLENGES AND POSSIBILITIES

SER ENFERMEIRO NA ESTRATÉGIA DE SAÚDE DA FAMÍLIA: DESAFIOS E POSSIBILIDADES

SER ENFERMERO EN EL PROGRAMA ESTRATEGIA DE SALUD DE LA FAMILIA: RETOS Y POSIBILIDADES

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ABSTRACT

The present study aimed at analysing the nursing challenges and career opportunities in the (FHS) in a Health District of Belo Horizonte, Minas Gerais. It is a qualitative study; data was collected through individual semi-structured interviews, observation and field diary. The study subjects were ESF nurses from seven health centres. The results demonstrated that the nurse's daily routine is characterized by work overload that impairs carrying out ESF specific actions. The challenges are the improvement of working conditions related to organization and care process; possibilities mean more autonomy so this professional can implement care practices more in tune with social policies.

Keywords: Working Conditions; Family Health; Health Services; Public Health Nursing.

RESUMO

O estudo teve como objetivo analisar os desafios e possibilidades do trabalho do enfermeiro na Estratégia de Saúde da Família (ESF) em um distrito sanitário de Belo Horizonte, Minas Gerais. Trata-se de estudo de abordagem qualitativa cuja coleta de dados foi feita por meio de entrevistas individuais com roteiro semiestruturado, observação e diário de campo. Foram sujeitos sete enfermeiros. Os resultados evidenciam que o cotidiano do enfermeiro na ESF é marcado por sobrecarga de trabalho que prejudica a realização das ações específicas da saúde da família. A implantação do Protocolo de Manchester fortalece a lógica da demanda espontânea em detrimento das ações de promoção da saúde. Os desafios perpassam a melhoria nas condições de trabalho, nos aspectos organizacionais e assistenciais. As possibilidades se traduzem em mais autonomia e potencial do enfermeiro em implementar práticas de cuidado mais coerentes com a política social.

Palavras-chave: *Condições de Trabalho; Saúde da Família; Serviços de Saúde; Enfermagem em Saúde Pública.*

RESUMEN

El objetivo del presente estudio fue analizar los retos y posibilidades laborales del enfermero en la Estrategia de Salud de la Familia (ESF) de un distrito sanitario de Belo Horizonte, Estado de Minas Gerais. Se trata de un estudio cualitativo cuya recogida de datos se realizó a través de entrevistas individuales con guión semiestructurado, observación y diario de campo. Los sujetos fueron siete enfermeros. Los resultados mostraron que el día a día del enfermero de la ESF se caracterizaba por la sobrecarga de trabajo que perjudicaba el quehacer de las tareas específicas de la salud de la familia. La implementación del Protocolo de Manchester fortalece la lógica de la demanda espontánea a expensas de las acciones de promoción de la salud. Los retos van más allá de la mejora de las condiciones de trabajo, en las cuestiones de organización y de servicios. Las posibilidades se reflejan en más autonomía y potencial del enfermero para implementar prácticas de cuidado más coherentes con la política social.

Palabras clave*: Condiciones de Trabajo; Salud de la Família; Servicios de Salud; Enfermería en Salud Pública.*

INTRODUCTION

The presence of nursing staff in the Family Health Strategy (ESF) has proved crucial to the expansion and consolidation of this programme, symbol of the reorganization of the Brazilian health care model. These professionals' duties encompass from the organization of the ESF activities and operation of the health centre, to the care to individuals, families and communities.

The ESF is a fundamental *locus* for nursing interventions. The nurses, in addition to technical skills, should build a permanent bond with the community to carry out specific individual and collective actions, according to their need and demands.

ESF professionals are supposed to deal with the health-disease-care process.[1]

Family health workers must meet targets, participate in meetings and at the same time meet the contingencies, which include demands for answers to problems that exceed users' programmes and administrative duties that often go beyond those previously stipulated.[2]

Primary health care constitutes a completely different scenario to the nursing staff. In addition to occupational risks faced in other levels of care, nurses face new challenges in the work organization process in order to meet the users' demands and to follow the guidelines for the reorganization of health services.[3]

Organized services enable nurses to allocate more time to diseases prevention and health promotion actions. Usually such activities are not carried out because too much time is spent in bureaucratic issues and spontaneous demand.

In addition, the organization of the nursing staff is essential to ensure quality of service. In this regard, besides the team, a new professional profile is required: one that is in constant need of training and continuing education. Furthermore, a good relationship between the staff provides appropriate assistance to users and quality of working life, preventing illnesses, absenteeism, feelings of powerlessness and frustration.

Nurses in the family health team deliver care and perform educational and administrative activities, contributing significantly to solve problems in the different levels of care. Considering the above and in view of the importance of nurses in the ESF, it is necessary to identify the experiences that form part of everyday routine within family healthcare.

Thus, the purpose of this article is to analyse the challenges and possibilities of the ESF nurses' work process in a Belo Horizonte health district.

METHODOLOGY

A qualitative research focuses on a world of meanings, desires, aspirations, beliefs, values and attitudes; a deeper space in the relationship between processes and phenomena.[4-6] Therefore, researchers must perform fieldwork to thoroughly investigate a phenomenon from the perspective of its players.

The study subjects were seven nurses from seven health centres in a health district of Belo Horizonte. Inclusion criterion was having more than five years' experience working in an ESF team, because having more professional experience meant having more relevant information about the study subject.

Data was collected during individual interviews with semi-structured and non-participant observation. The semi-structured interviews comprised the following guiding questions: Can you introduce yourself and tell a little bit about your background? What does it mean to you to work as a family health nurse? How do you feel about your job? Talk about your daily work as a family health nurse. The nurses were reached by phone and the interviews were previously scheduled. They were held at the health centre, in a reserved place on date and time chosen by the research subjects.

The interviews were recorded and later transcribed in full. In order to ensure their anonymity the subjects were identified by the letter "E" followed by a number corresponding to the order of the interview (e.g. E1). The data were analysed by Laurence Bardin's content analysis.[7] This methodology divides the analysis process into the following chronological stages: pre-analysis; exploration of material; treatment of results; inference, and interpretation.

Pre-analysis consisted of preparation and thorough reading of the material. After transcription, the interviews were ordered according to the questions of the semi-structured interview. At this stage, the objective was to separate convergent and divergent aspects of the interviewees' accounts and draft preliminary analytical categorizations. A systematic reading of the interviews highlights the study subjects' perceptions, which enables researchers to reflect on their experiences during fieldwork and retrieve experiences observed and recorded in the field diary. The following stage, exploration of the material, aimed at taking hold of relevant elements mentioned by the study subjects. At the subsequent stage, data was processed through categorization of relevant topics, which were then analysed and compared in the light of the literature. This stage informed the subsequent discussion amongst the authors that tackle the statements content in order to expand the analysis and develop the investigation.

The research project was approved by the Ethics in Research Committee of the Federal University of Minas Gerais (Protocol No 0128.0.203.000-10) and the Ethics Committee of the Municipality of Belo Horizonte (Protocol No 006.2012A) in accordance with the National Health Council Resolution No 466/2012 on the Guidelines and Norms Regulating Research with Human Beings of the Department of Health.

RESULTS AND DISCUSSION

Conflicts related to their professional practice and their expectations of their performance permeated the routine of the study participants. Such conflicts arise from the ongoing struggle for new ways to treat health care in a context in which management strategies and ideological aspects that reinforce the established model predominate.

Work overload is one of the prominent characteristics of nurses' daily routine. It originates from the need to answer to questions related to health centres operation, meet the needs of the population, to set goals, and establish pacts and indicators. Nurses are also responsible for health promotion and disease prevention, identification of risks and intervention.

Despite knowing their duties, nurses consider that work overload has a negative impact on quality of care. Such context leads to feelings of frustration and doubt as to their performance in the ESF.

> *We know that work overload is a big issue that prevents us from dedicating ourselves to the ESF as we would like to do. I have to remain in the unit and then go out to check on the community agents; and we know that we don't do it well [...] And as there are two realities here, family health care and spontaneous demand [...] the same nurse that stays here delivering care has to go out to visit the people. We have no time to sit down with the community agents to programme and organize other things, you know? (E5).*

A previous research[8] reveals that work overload and backlog jeopardise the team's actions, the longitudinal care plan and the accomplishment of ESF recommended interventions. The authors report difficulties regarding management and health care accountability that require urgent answers and move away from the reality and needs of the population.[8]

The daily routine of nursing care is characterized by the conflict of being responsible for the operation of the health centre activities and the specific ESF duties. The pressure imposed on nurses is not proportional to the conditions offered to the provision of a quality health care and the fulfilment of spontaneous demand. Consequently, they experience conflict situations in decision-making, recognizing that some activity will be neglected so that another can be carried out.

In Brazil, two antagonistic health care models coexist. One is centred on the user's complaint/demand, focused on treatment, cure and one-off interventions always from an individual perspective. The other one is based on health promotion practices that encompass the users' needs. This means that interventions favour the prevention of illness and the improvement of health, based on collective practices and focusing on health determinants, guided by a longitudinal and comprehensive health care perspective.

Regarding the difference between health demand and needs, the first one is the response to a need translated into an available offer. That is, within the activities promoted at the health centre, the language of disease speaks higher. Therefore, such health needs are modelled and emerge as users' demands for health services to be granted.

Health needs, on the contrary, concern real demands that go beyond biological questions and are even related to the users' unique sense of happiness, encompassing various life dimensions. In order to seize and capture such needs, nurses should be able to attentively listen to patients, aiming at understanding the meaning behind the subjects' speech considering their life circumstances, values and beliefs.[9]

To remove activities with groups of healthy people in order to address acute illnesses already in place strengthens the notion that health services are supposed to treat diseases and not to build health.

> *Very large demands also hinder, for example, the welcoming service. Spontaneous demand is very large and that disrupts too. The amount of acute cases in the health centres today justifies better equipped APSs. I know that there is a local government project to expand these APSs; it may be needed (E3)*

> *We have a daily schedule: Monday mornings I'm working with the Manchester risk assessment. [...] we are like machines, we are there for assessment and if we see something that needs intervention we can't do it! We have to be in a medical consultation room, that's why. Then, if we need something, it's out of the Manchester and the time we have is allotted to classification. Well, that limits a lot our work (E6).*

The implementation of the Manchester Protocol in Primary Health Care (APS) makes it clear that ESFs are organized according to spontaneous demand. As reported by the guidelines of the training course on Risk Assessment in an Emergency Service promoted by the Distance Education Centre of the State Department of Health of Minas Gerais, screening and risk classification is a clinical management risk tool to control patient flow when clinical demands exceed supply.[10] Thus, risk assessment is a strategy that aims at systematizing care enabling the assessment of users according to their health conditions.[11]

The Manchester Triage System (MTS) is a judicial prerogative because it prioritizes not the first individual who arrives but the one whose medical condition requires immediate care. The Risk Rating methodology is internationally recognized and used in countries like Portugal and the United Kingdom.[10]

The MTS reasoning is perfectly suitable to the emergency services dynamics, and consistent with the goals and specificity of these services. In contrast, the implementation of such system to health centres with different objectives is questionable.

Even if the health centre is the gateway to emergency care as specified in the National Policy for Emergency Care, [12] its organization needs not to be considered under those lines. The focus of ESF actions is the reorganization of care practice, assuming that the users' health needs and not their complaint / demand are priorities. The implementation of the MTS at the APS can be considered as an organizational setback: the system does not respond to the ESF principles and furthermore it shies away specific family health actions, as evidenced in the following account:

> *As the Manchester (system) is a quick thing, because they [users] come, they have a complaint, they come in, take the medicine for a specific purpose. There is no monitoring, nothing and for them everything's solved. But it is not only that, right? So I think that the system has really spoiled the awareness process of the users (E6).*

Such evidence suggests that the implementation of the MTS has reinforced healthcare practices focused on one-off interventions that contribute to the durability of the biomedical model in the health care system and in the population mind-set too.

By prioritizing an approach based on the body and the disease translated in the language of clinical signs and symptoms, it is evident that the implementation of the MTS in the APS supports biopower strategies in health care practices. This policy privileges intervention on biological grounds, supported by scientific knowledge and technical expertise established as power-knowledge, creating mechanisms of control and domination of the subjects.[13]

The implementation of the MTS in the APS prioritizes a management tool that conceals the real health needs of individuals and submerges it in the language of the disease. Such strategy has historically characterized health organizations for a long time.

The practices carried out in the APS should promote and strengthen ties between professionals and the community establishing a co-responsibility relationship between the health professional and the user. Therein, welcoming services are potentially capable of carrying out the new work process proposed by the SUS.

Welcoming is an operational guideline based on the principles of universality and equity through the reorganization of health practices. It is a strategy that questions interceding processes building relationships out of clinical health practices. It enables you to listen to echoes of how daily work is captured, depending on the type of care and wherever such relationships are established.[14]

To welcome means to receive, to greet and also to accept the other as an individual with rights and desires and as co-responsible for the production of health; from the perspective of individual and collective care. It involves a theory of relationships and complementary professional skills, as well as favourable psychosocial, biophysical environmental conditions.[15]

Service organization cannot be dependent on the demand. In this regard the proposal of the SUS is to prioritize investment of prevention and health promotion actions. However, professionals still operate under a curative and fragmented approach.[16]

Excess demand has become the hallmark of the ESF since, according to its principle, everyone has the right to have access to health care services. The main entrance is primary care that guarantees the principle of equity in care.[17] This causes ESF fundamental activities to be pushed into the background. Thus, there are few situations in which nurses can leave the health centre and intervene directly in the community in order to understand the territory where the processes of being healthy and sick are taking place; to get acquainted with the individuals, their affections, their way of life, their relationships, their culture and their ways of living.

The performance of those activities specific to the nurse, such as nursing supervision, preparation of Standard Operating Procedures (POP), ACS and nursing staff training is also limited by work overload. Nursing visits are carried out, but the nurse still can be asked to meet other demands:

> *We now rarely carry out nursing supervision [...] we cannot set up a nursing meeting; we cannot define the POP, which is something that should be done [...]. We insist upon doing the nursing visits, but there is always someone knocking at your door asking for some other problem to be solved. So ... so we're in the consultation room and have to meet other needs (E7).*

A study dealing with the work process of family health nurses and childcare practices demonstrated that in some situations nursing visits are no longer held due to the high rate of other demands brought to their attention. If they are held, all of their allotted time is spent with the mothers' clinical complaints. They do not cover those comprehensive and curative issues to be tackled during the nursing visits.[18]

It is worth mentioning that the inadequate infrastructure has an impact on the daily practices of the ESF nurses. Most nurses complain about the lack of a consultation room. There are no adequate and specific spaces for them to perform their duties. Such is the situation in the following statement:

> *The facilities are really bad for any professional to work here: no room, we nurses, for example, can use one room twice a week for two hours only. [...] To childcare, antenatal ... but for the Manchester and other activities we have to find a place that does not exist for other activities, right? For example, we also hold the groups there in the yard, by the jaboticaba tree. But, if it rains we can't hold the childcare group; too complicated if you have to take off the baby's clothes. We cannot do it! (E1).*

Decree No 2488 / 2011.19[19] which reviews the implementation of primary care and ESF guidelines and standards recommends making available a medical and nursing office, a dental office and a consulting room with a WC, as well as a welcoming multi-room to spontaneous demand.

The improvement of the working environment contributes to the staff's motivation, creativity and productivity. It has an impact not only on relationships but also on the qualification of practices. The Department of Health through the National Humanization Policy,[20] defines ambience as the treatment of the physical space established as a social space, professional and interpersonal relationships that should provide warm, humane and solution-driven attention.

The characteristics of the workplace can significantly influence the quality of life of workers and the activities developed. To this end, according to the Department of Health, [21] that space should allow for the reflection of the subjects in relation to each other and the work; it should provide comfort, privacy and individuality and contribute to the improvement of the working process.

Nurses get immersed in a daily routine characterized by work overload and limited infrastructure that makes their practice little reflective and generates alienation.

> *What I see is that nurses do not have a critical view, you know; they don't have it. They get so immersed in their work.... they come in, there is a welcoming reception, and then they have to cope with the demand; they cannot even think about what they're doing. Very uncritical, but this is the idea I have of my co-workers (E7).*

In order to be qualified as a praxis, the practice must be articulated with reflection, building a cyclical movement between "doing and thinking about doing".[22] A critical reflection on one's own practice makes it possible to overcome alienation. Work overload is the result of the accumulation of norms that hinder nurses' ability to reflect about their practice.

In this scenario, nurses must make decisions involving ethical issues on the access to health services. According to the law, such access is universal but in practice it is not feasible given the lack of structure. Therefore, "the nurses move between the managers' and the profession's contradictory and conflicting prescriptions and create new ways of working" [23]. They try to reconcile the formal requirements of health policies with the legal requirements of professional practice.

The construction of the nurses' manner of being involves attitudes and decision taking about a reality that requires self-management: the nurse performs a wide range of activities in primary care. In addition to objective issue, the nurses are engaged with the subjectivities characteristic of healthcare work. They need to exercise their ability to self-manage which involves choices, values and decision making.[17]

Reflecting on the work process itself nurses are able to refine demands that are exclusively theirs from those that can be shared with other professionals.

The accounts of the study subjects are an appeal for support so that they can perform their ESF duties. A support nurse would take care of the activities related to the operation and organization of the Health Centre:

> *The problem here is that without nursing support we are the ones in charge of the team and of the units (E6).*

> *I also think there is a lack of human resources; we have no nurse support (E1).*

Support staffs to cover spontaneous demand would be a strategic tool for organizational management. The support team would be responsible for the welcoming and risk assessment and would carry out dressings, vaccines and other demands of the health centre.

The study participants highlighted the importance of strengthening the bonds with the community, considered as a nursing recognition:

> *The bond with the community helps a lot. It is very good when we can bond; it is very rewarding for us. I really think that the bond we have created with the community is the main thing. There were cases in which the patient preferred my schedule, my nursing consultation than the doctor's. Not because of the doctor not being good, but because of the bond, you know? The doctor is excellent, also very nice, but it is because of the bond, that's what happens (E1).*

E1's statement stresses community link as an element that can help in the relocation of ESF nurses within healthcare practices in order to give them more visibility because they are recognized by the community for their skills and their professional role.

Bonding allows nurses to be seen by the community as trustworthy people who are near the family group and to whom individuals can appeal if necessary.[24]

Another facilitating factor for such nurses' work is that they perform their tasks in an ascribed area and that they are working with a committed team:

> *Now, I've been working here for four and a half years, I know the community well [...]. My team is very committed to their work, not all of them, but most of the team. I think those are very positive things. (E6).*

The nurses' accounts highlight teamwork as key element in their ESF activities. The healthcare model has undergone some changes and now teamwork is closer to the recommended dimension as it enables new ways of interaction between professionals, guided by horizontality and by the appreciation of different kinds of knowledge.

> *We do a good job in terms of teamwork because we are really a team. Our team has been around for ten years already, right? Ten years working with the same team. The community agents changed; two left, two came in. We make a point of meeting all week to discuss issues. The team spirit we managed to build is fundamental in family health (E5).*

Teamwork in family health services requires an understanding of several disciplines to deal with the complexity of primary care. Primary healthcare services are provided by the healthcare team in a personal, family and social context. The complexity of working within a community requires collective action of those responsible for a specific area and this is what recognizes the singularity of the ESF strategy.

FINAL CONSIDERATIONS

The ESF is a strategy adopted to make real changes in the health care model and to consolidate the SUS in Brazil. The ESF nurses face the possibility of increasing their autonomy through a practice based on comprehensiveness of care and care for communities and for families through the lifecycle.

This study analysed specific characteristics of ESF nurses of a health district in Belo Horizonte. It identified challenges and possibilities that permeate their professional practice. The results show that the nurse's daily routine in the ESF is typified by the conflict of being responsible for a set of activities that make up the dynamics of the health centre and those specific duties of this model of care.

The challenges are increased workload and the organization of spontaneous demand and of the infrastructure. Work overload, mainly due to spontaneous demand and to activities that go beyond those programmed, undermines family health activities, such as health promotion, disease prevention and home visits. This reality generates alienation given the little opportunities the nurses have for reflection on the practice itself.

As an alternative, the study subjects suggested the implementation of support teams. Support nurses can act specifically on activities related to the health centre, fulfilling spontaneous demand and freeing up ESF nurses to perform specific activities.

Most professionals stated that the difficulty to perform their duties due to the lack spaces for nursing visits was another challenge. Nurses who do not have a proper space to develop specific activities need to wait for others to finish theirs so that the rooms become available.

Despite the numerous difficulties encountered in their daily professional routine, these nurses are conquering their social recognition from the team members and the community. Moreover, they are aware of the potentialities like using their experience in hospitals, in establishing bonds with the community and in interacting within a team.

Professionals highlighted that family health care services need to galvanise knowledge about emergency assistance to meet the demands of primary care. This experience is considered a facilitating factor to the development of care practices.

Bonding was mentioned as a means to the relocation of ESF nurses within health practices with a view to the community's recognition of their professional contribution thus giving it more visibility.

Another potentiality mentioned in the nurses' accounts as key element to their performance within the ESF was the ability to work with a team. This reality reinforces the importance of establishing interpersonal relationships that provide a productive, healthy and fulfilling work environment.

The analysis of the specific characteristics of the ESF nursing duties, in particular with respect to the challenges and opportunities, can contribute to the development of interventions aimed at improving the organizational and professional practices and therefore health care delivered to the population.

The limitation of this study is the fact that data was exclusively geared to nurses' point of view.

The Family Health Strategy is a programme whose practice is focused on the family and is performed by multidisciplinary teams. A broader and more relevant understanding of the subject would call for an analysis from the perspective of staff and users, individuals with whom nurses relate on a daily basis and with whom they build their social practice.

Thus, the study results encourage future studies aiming at examining the design of different players who share the daily life of the Family Health Strategy nurses and experience the uniqueness of working in this field of knowledge and practice that integrates the Brazilian health care model.

REFERENCES

1. Menezes RMP, Pinto ESG, Villa TCS. Situação de trabalho dos profissionais da Estratégia Saúde da Família em Ceará-Mirim. Rev Esc Enferm USP. 2010; 44(3):657-64.
2. Santos VC, Soares CB, Campos CMS. A relação trabalho-saúde de enfermeiros do PSF no município de São Paulo. Rev Esc Enferm USP. 2007; 41(N. Esp):777-81.
3. David HMSL, Mauro MYC, Silva VG, Pinheiro MAS, Silva FH. Organização do trabalho de enfermagem na Atenção Básica: uma questão para a saúde do trabalhador. Texto Contexto Enferm. 2009; 18(2):206-14.
4. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo: Hucitec; 2004.
5. Goldenberg M. Pesquisa qualitativa em ciências sociais. In: Goldenberg M. A arte de pesquisar: como fazer pesquisa qualitativa em ciências sociais. 11ª ed. Rio de Janeiro: Record; 2009. p.16-24.
6. Chizzotti A. A pesquisa qualitativa em ciências humanas e sociais: evolução e desafios. Rev Port Educ. 2003; 16(2):221-36.
7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2009.
8. Baratieri T, Marcon SS. Longitudinalidade no trabalho do enfermeiro: identificando dificuldades e perspectivas de transformação. Texto Contexto Enferm. 2012; 21(3):549-57.
9. Cecílio LC. As necessidades de saúde como centro estruturante na luta pela integralidade e equidade na atenção em saúde. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: UERJ/IMS/ABRASCO; 2001. p.113-26.
10. Minas Gerais. Secretaria de Estado de Saúde de Minas Gerais. Classificação de risco em urgência e emergência Protocolo de Manchester. Belo Horizonte: SES-MG; 2011. p. 1-8.
11. Silva KL, Sena RR, Seixas CT, Silva MEOS, Freire LAM. Desafios da política para a promoção da saúde no cotidiano dos serviços. REME - Rev Min Enferm. 2012; 16(2):178-87.
12. Brasil. Ministério da Saúde. Política Nacional de Atenção às Urgências. 3ª ed. Brasília: Ministério da Saúde; 2006.
13. Foucault M. Microfísica do poder. Rio de Janeiro: Edições Graal; 1979.
14. Franco TB, Merhy EE. PSF: contradições de um programa destinado à mudança do modelo assistencial. Campinas: UNICAMP; 1999.
15. Inojosa RM. Acolhimento: a qualificação do encontro entre profissionais de saúde e usuários. In: X Congresso Internacional Del CLAD. Santiago: CLAD; 2005. p.18-21
16. Schrader G, Palagi S, Padilha MAS, Nogues PT, Thofehrn MB, Pai DD. Trabalho na unidade básica de saúde: implicações para a qualidade de vida dos enfermeiros. Rev Bras Enferm. 2012; 65(2):222-8.
17. Montenegro LC. A formação profissional do enfermeiro: avanços e desafios para a sua atuação na atenção primária à saúde [dissertação]. Belo Horizonte: Escola de Enfermagem, Universidade Federal de Minas Gerais; 2010. 98 f.
18. Assis WD, Collet N, Reichert APS, Sá LD. Processo de trabalho da enfermeira que atua em puericultura nas unidades de saúde da família. Rev Bras Enferm. 2011; 64(1):38-46.
19. Brasil. Lei nº 11.350, de 5 de outubro de 2006.Dispõe sobre o aproveitamento de pessoal amparado pelo parágrafo único do art. 2º da Emenda Constitucional nº 51, de 14 de fevereiro de 2006, e dá outras providências. Diário Oficial da União. 5 out. 2006.
20. Brasil. Ministério da Saúde. Portaria nº 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Diário Oficial da União. 21 out. 2011.
21. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Ambiência. 2ª ed. Brasília: Ministério da Saúde; 2007.
22. Brasil. Ministério da Saúde. Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: ambiência. Brasília: MS; 2004.
23. Bertoncini JH. Entre o prescrito e o real: renormalizações possíveis no trabalho da enfermeira na Saúde da Família [tese]. Florianópolis: Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem; 2011. 147p.
24. Monteiro MM, Figueiredo VP, Machado MFAS. Formação do vínculo na implantação do Programa Saúde da Família numa Unidade Básica de Saúde. Rev Esc Enferm USP. 2009; 43(2):358-64.