

Comprehensive health care: dilemmas and challenges in nursing

Cuidado integral em saúde: dilemas e desafios da Enfermagem

Cuidado integral en salud: dilemas y retos de la Enfermería

**Marluce Maria Araújo Assis¹, Maria Angela Alves do Nascimento¹,
Maria José Bistafa Pereira², Erenilde Marques de Cerqueira¹**

¹Feira de Santana State University, Department of Health. Feira de Santana, Bahia, Brazil.

²Ribeirão Preto College of Nursing, University of São Paulo, Department of Maternal-Child Nursing and Public Health. Ribeirão Preto, São Paulo, Brazil.

How to cite this article:

Assis MMA, Nascimento MAA, Pereira MJB, Cerqueira EM. Comprehensive health care: dilemmas and challenges in nursing. Rev Bras Enferm. 2015;68(2):304-9. DOI: <http://dx.doi.org/10.1590/0034-7167.2015680221i>

Submitted: 11-04-2014 Approved: 02-06-2015

ABSTRACT

Objective: this article discusses comprehensive care as a guiding tenet of the Brazilian Unified Health System (SUS), outlining health care practices, especially nursing, and the relationships built by subjects in action by means of different knowledge.

Methods: this is a theoretical reflection that aims to propose dimensions of analysis (access to services, reception, links, lines of care, accountability, and responsiveness), with an emphasis on the dilemmas and challenges of nursing. The proposed dimensions analyze the production of care and its political and technical aspects. **Conclusion:** care should be the focus of all health care work, bearing in mind that intervention for technological action of each profession goes beyond the core of isolated knowledge, as is the case of nursing, which is connected to other professional practices, and can peruse other territories that operate through relational technologies, entering into the world of the needs of users and families.

Key words: Health System; Nursing; Comprehensive Health Care; Nursing Care.

RESUMO

Objetivo: o texto discute o cuidado integral como um caminho orientador do Sistema Único de Saúde (SUS), demarcando as práticas de saúde, em especial da Enfermagem, e suas relações edificadas pelos sujeitos em ação por meio dos diferentes saberes.

Métodos: trata-se de uma reflexão teórica com o objetivo de propor dimensões de análise (acesso aos serviços, acolhimento, vínculo, linhas de cuidado, responsabilização e resolubilidade), enfatizando os dilemas e desafios da Enfermagem. As dimensões propostas analisam a produção do cuidado, seus aspectos políticos e técnicos. **Conclusão:** considera-se que o cuidado deveria ser foco de todo o trabalho em saúde, tendo em vista que a intervenção para a ação tecnológica de cada profissão vai além do núcleo de saber isolado, como é no caso da Enfermagem que, se conectado a outras práticas profissionais, pode trilhar outros territórios que operam por meio de tecnologias relacionais, adentrando para o mundo das necessidades dos usuários e famílias.

Descritores: Sistema de Saúde; Enfermagem; Assistência Integral à Saúde; Cuidados de Enfermagem.

RESUMEN

Objetivo: el texto aborda la atención integral como un trazado de rector del sistema único de salud (SUS), demarcando las prácticas de salud, especialmente de enfermería y sus relaciones construidas por los actores en acción por medio de diferentes conocimientos.

Métodos: es una reflexión teórica para proponer dimensiones de análisis (acceso a servicios, acogimiento, vínculo, líneas de atención, responsabilidad y resolución), haciendo hincapié en los dilemas y retos de la enfermería. Las dimensiones propuestas analizan la producción de cuidado, sus aspectos políticos y técnicos. **Conclusión:** se considera que cuidado debe ser el foco de todo el trabajo en salud, teniendo en cuenta que la intervención a la acción tecnológica de cada profesión va más allá del núcleo de saber aislado, como es el caso de enfermería, que está conectada a otras prácticas profesionales, puede perseguir otros territorios que operan a través de tecnologías relacionales, entrar en el mundo de las necesidades de los usuarios y sus familias.

Palabras clave: Sistema de Salud; Enfermería; Atención Integral de Salud; Cuidados de Enfermería.

CORRESPONDING AUTHOR Marluce Araújo Assis E-mail: aassis@uefs.br

INTRODUCTION

The ideas presented in this text are synthesized in reflections that the authors have been developing in recent years, based on collective theoretical discussions and practical experience, experienced by professors and researchers of the Center for Integrated Research in Public Health in the Department of Health of the Feira de Santana State University and other partner institutions, involving groups and researchers in nursing and public health.

This article seeks to consider the production of comprehensive health care, which necessarily includes reflection on the Brazilian Unified Health System (SUS, as per its acronym in Portuguese). The numerous discussions on this subject have spurred challenges to conceptions of models of health care, causing tensions that propel further reforms in ways of thinking and doing health care in the daily services and practices in the SUS. That is, to consider comprehensiveness as a guiding tenet of the organization of care, the network of care and policies, implies dialogue and democratic interaction of the subjects involved in the construction of responses capable of considering the differences expressed in the demands in health care⁽¹⁾.

In this sense, the practices learned during the process of care production would have to address the needs of users with tools that go beyond implementation of technical, scientifically-based knowledge, but which are also drawn from political, organizational and symbolic fields. Specifically, this means putting at the center of the discussion the way care has been outlined in the daily services that can respond, in large part, for the low impact of the actions produced and the dissatisfaction of users in relation to the system. One of the weaknesses of these actions is the structuring of the health care system, still focused on procedures, with a core technology that values biomedical knowledge and practices as guiding principles in the production of health care actions.

Health care services need to assume one of its most important tenets: to promote intervention focused on the user that is capable of enabling autonomy of individuals in their lifestyles, without losing sight of the dimension of care that should be present in every health care action. It is through dialogue and negotiation, marked by intersubjectivity between worker and user, that it is possible to find ways to meet the needs set forth at this meeting.

That said, it is important to reflect on the operating mode of health care (and nursing) practices, and its interfaces with the SUS system, as well as the purpose of these to meet the needs of system users.

Such practices are social and historical, and recognize the nuclei of specific and interconnected skills operating in individual and collective care, demarcated by health care (care practices) as the possibility of more comprehensive and better quality health care work. In this perspective, the powers and questions that permeate the practices are highlighted, with openness to creativity and innovation. Workers need to step aside and let of their centrality, guided by systematic and univocal knowledge. Workers need to facilitate, and must produce encounters among people for the passage of flows, affections and desires in an intersubjective manner⁽²⁾. Management

practice is inserted as part of this care, with actions of coordination, supervision, evaluation and educational practice, which is produced in acts, orientation processes, dialogue and negotiation among staff, users and families.

Thus, the incorporation of comprehensive practice is one of the challenges in building a universal and equitable health care model, considering that the work of nursing in primary care has two dimensions: care and management. The first, focused on individual and public care, and the second, on actions of coordination and supervision of care, are both prevalent in nursing, constituting a human work process in the field of health, which is first and foremost the production and reproduction of social humans, historically determined by producing goods and services geared to health needs⁽³⁾.

However, when taking the practice of nursing as the object of analysis, its centrality in everyday dynamics of health care (individual and public), through activities of promotion, prevention of disease, recovery and rehabilitation of health, indicates interfaces with other knowledge and practices.

Nursing is responsible for the care, comfort, embracement and well-being of patients, by providing care and coordinating other sectors for the provision of care, and promoting patient autonomy through health education⁽⁴⁾.

In this perspective, the process of health care education would have to recognize the coexistence of scientific knowledge and applied science with life standardization strategies, thereby placing in health care practice possibilities of aligning different modes of living and lifestyles in processes of micro-political meetings between health care workers and users⁽⁵⁾, encouraging freedom and the possibility of exercising creative capacity for problem solving in the exercise of care.

What must be emphasized here concerns the relationships built by the subjects in action, to produce care that establishes connections with different knowledge, practices and people. Thus, to discuss comprehensive health care requires critical reflection on the political, organizational and technical dimensions that guide it.

The political dimension involves access to health care services in their complexity and polysemy⁽⁶⁾; the organizational and technical dimensions are portrayed in meetings, in distinct spaces of the care network, by incorporating the relational dimensions (embracement and bond) to the clinical, and enable specialist orientation and the consolidation of lines of care for the resolution of real and symbolic health problems/needs⁽⁷⁾. The production in the field of nursing lacks reflections that address dimensions of analysis based on the fields above, considering that studies in this direction were not identified. This production concerns specific clippings⁽⁸⁻⁹⁾ or the process of care related to the organization of work in health and nursing⁽¹⁰⁾.

The aim of this study was to propose analytical dimensions for the production of comprehensive care in the SUS network, emphasizing the dilemmas and challenges of nursing. The dimensions shown in Table 1 provide the potential to develop studies for critical and reflective analysis of the object of study.

Table 1 - Dimensions of analysis of the production of comprehensive health care⁽⁶⁻⁷⁾

| Dimension of analysis | Definition |
|--------------------------------|---|
| Access to health care services | This dimension crosscuts all health care practices, and involves aspects related to practice (technical) and the organization of care, as well as political, economic, social and symbolic aspects, from access at the entrance to exit from the health care network(6). |
| Embracement | This involves establishing relationships with the model of health care and quality of services, and accountability as product and producer of care. After all, health care professionals who actively coparticipate in the health problems of people, listen and talk, establish accountability in two ways, providing care - and inexorably establish embracement and vice versa(6). |
| Bonding | Bonding enables exchange of knowledge between the technical and the popular, the scientific and empirical, the objective and subjective, converging them to perform therapeutic acts shaped by the subtleties of each public and person, delineating other meanings for comprehensive health care(7). |
| Lines of care | Organization of production processes of care in the network from various fields of knowledge and practice, at the individual and collective level, in the construction of a comprehensive and effective health care model. |
| Accountability | Accountability in the act of caring for people, in a movement aimed at expanding the therapeutic act, valuing the uniqueness of each service user, in a manner that is shared among staff, users, families and managers of the system. |
| Responsiveness | Responsiveness to demands according to individual and collective needs, whether at the entrance or other levels of the system. |

ANALYSIS DIMENSIONS OF THE PRODUCTION OF COMPREHENSIVE HEALTH CARE

The dimensions of analysis are summarized in Table 1: access to health care services, embracement, bonding, lines of care, accountability and responsiveness. The aim is to establish connections in the organizational dynamics of the network, in its political and technical aspects.

The first dimension is political, and considers access to health care services as a category of analysis of health care policies, relating it to living conditions, income and education, and encompassing accessibility to services that goes beyond the geographical. It also involves other issues, including economic (user spending on the service), cultural (beliefs, values and identities of social groups), and organizational (flow of care, supply and demand of practices and services), in accordance with the requirements of the population⁽⁶⁾.

Access is a complex and fundamental theme, present in the international literature⁽¹¹⁻¹³⁾, concealed by economic difficulties and barriers related to lines to schedule consultations and medical care. Whereas 80% of the health care needs of the population can be resolved in primary health care (PHC), the organization of care at this level is pressing, involving the location of the unit close to the population it serves, timetables and days when it is open to treat people, the degree of tolerance for unscheduled consultations, and how much the population perceives the convenience of these aspects of access⁽¹³⁾.

In the national context^(6,14), access is discussed in different perspectives, involving the availability of health care resources and the capacity of the public network to produce services that respond to the needs of the population. In this sense, health care workers recognize the limitations of access to the Family Health Strategy (services inaccessible to the

community, lack of training and insufficient number of workers) and the strengths (communication between community agents and communities, provision of educational information and focus on care of children). Thus, having access to health care services not only means an entry of the users to the primary health or hospital network, but also seeking care that attends to their health care needs, transforming the reality⁽¹⁵⁾. Quality access to health care services improves peoples' lives, considering that by obtaining access to services, users have their demands and needs met.

Inequalities of access are one of the main challenges to be overcome so that the Brazilian public health care system is responsive, in accordance with its established principles and guiding directives. In this sense, the production of comprehensive care should be designed and implemented according to socially determined needs, in addition to intervening in reality, in an articulate manner in which accountability is shared⁽⁶⁾.

Embracement is the second dimension of analysis in the formation of a new practice, valuing communication of the health care team with users, as a space for attention and active listening, giving appropriate responses to each person during the entire process in health care units (embracement, attendance by means of consultation, external referral, follow-up, rescheduling and discharge). Embracement provides a range of services needed, as well as full accountability for the health problems of a collectivity, by means of available technologies, valuing light technologies and recognizing their relevance in health care⁽¹⁶⁾. Bonding is the third dimension, and can enable the expansion of relational bonds, developing affection and increasing the potential of the therapeutic process. In this sense, shared accountability is paramount, that is, the ability to perceive singularities and invest in individual and collective capacity to make choices⁽¹⁷⁾.

Thus, bonding must be inherent to teamwork, in order to solidify shared and pleasurable work, placing the user at the center of the process of producing practices.

The fourth dimension is cross-cut by lines of health care, conceived as institutional arrangements and ways of managing micropolitics of a particular service or institution, so as to result in work based on solidarity and responsiveness on the part of all health care workers, to meet the needs of users⁽⁵⁾.

Work would have to be integrated and not fragmented, gathering in the production chain of care a cast of programmatic actions and services the unit offers, and referrals to specialized consultations (medium level), tertiary services, domiciliary hospitalization and other community services⁽¹³⁾.

Without breaking the isolation, without the production of new technologies for health care, and without putting the construction of lines of care on the agenda of management of the system (breaking with the isolation of the basic care and with the bureaucratic hierarchy), it will be difficult to break with hegemonic concepts and practices of health care, or to produce quality health care that meets the expectations of users. All these elements are indispensable to the policy of consolidating the SUS.

Accountability, the fifth dimension of analysis, seeks to face the challenges of the health-disease process, incorporating into the therapeutic act the appreciation of the other, concern with care and respect for the worldview of each person. Therefore, accountability is to aid the strategies of promotion, prevention, cure and rehabilitation of users.

Responsiveness goes far beyond the technical effect that health care professionals can achieve, and simultaneously involves practical success, namely, the appropriate response so that users and communities understand what life and health mean in their contexts. In this perspective, it involves issues that relate not only to the organization of care, but also professional conduct and the relationships established between health care teams and users⁽¹⁸⁾.

Thus, responsiveness is closely related to the act of embracement, since the identification of health care needs involves the incorporation of the diversity of people who demand the health service for the production of care. Tolerance of differences is fundamental in the relationship between professional health workers and users, and, therefore, the practice of listening needs to be developed considering the situational singularity of each user. This will make it possible to expand identification of needs and potentials for practice guided by comprehensiveness.

The proposed dimensions refer to meeting health care needs, according to the precepts of the SUS, since they seek to discuss the organization of practices as part of an articulated health care system, resulting in greater satisfaction of workers and users, in relational dynamics, without losing sight of political and technical aspects which underpin the health care system.

DILEMMAS AND CHALLENGES OF NURSING

Health care, in particular nursing, as one of the professions responsible for care of individuals and the public, is redefining its knowledge and practices, seeking to prioritize the

discussion of meanings related to the construction of subjects to solidify a new health care model.

When cutting to the cores of nursing skills⁽¹⁹⁾, dilemmas are present regarding practice. On the one hand, intervention is focused on managing therapy by nursing staff, with the tensions inherent in the hierarchical process and relationships between people and, on the other hand, requires articulation with the various nuclei of knowledge and practices to exercise the role of a collective worker with a comprehensive and interdisciplinary character.

When the institutionalization of nursing is recovered, a retreat of intervention in the domestic, private and family sphere is observed, to a movement of insertion in the public space, even in the 19th century, with the re-structuring of health care systems and the resizing of practices in the national context, with a predominance in the global scenario, still of private acts geared to individual care⁽²⁰⁾.

This panorama is based on scientific rationality, aligned with technologies that emerge from the productive processes that lead to capitalist society. However, due to the fact that nursing adopts care as the essence of its work, it cannot dispense with intersubjective and humanized relationships that permeate encounters with users and families in the daily practice of health care services. This, without losing sight of other important elements such as beliefs, gender relations, religion and ethics, among others, seeking interface with scientific rationale. That is, humanized and therapeutic encounters are needed, articulated by teamwork projects.

Thus, care can be placed as a symbol of the essence of the field of health care, that should be a place that cares for individuals and the public, in the act of its production and how care is performed, directed, which, after all, is the purpose, if they are going to meet the world of the users with receptivity of actions and services provided.

In this sense, one of the dilemmas experienced by nursing resides in how care is performed on a daily basis: fragmented, focused on specific aggravations and centered on health care professionals. One of the main challenges is the construction of new therapeutic bases to ensure comprehensive care, as opposed to a technical model that is individualized and focused on disease, biological knowledge and individual professional action.

It aims to achieve health lastly, which extrapolates the normative horizon established by biomedicine, of a techno-scientific character, in which it relates only to morphofunctional normality. Health is expressed as a value of contrafact and intersubjective character that will never be complete, because it depends on the relentless and continuous search for ideas of well-being while one is alive, i.e., the pursuit of health is oriented by a kind of normative horizon, which can be called the "happiness project," that will always be unfinished and under construction⁽¹⁸⁾.

The complexity of the challenge is to assume the production of comprehensive care as inherent to health professions and as a consequence of nursing practices, which should align with the principle of comprehensiveness, defended in the premise of the SUS. This seems to be one of the great dilemmas: its precise definition and its operationalization.

However, these dilemmas do not reduce its importance. The legitimacy in producing comprehensive care constitutes a fundamental mechanism to strengthen the other two principles, universality and equity.

For this purpose, it is necessary to think in two directions: a policy which extends the commitment of governments and managers of the system in the formulation of guidelines that enable the redesign of financing and the model of management and health care. In this perspective, the increase in supply of services would supercede bureaucratic and productivist criteria by overcoming the repressed demand for health care services⁽⁶⁾ at the same time when the intermunicipal agreement would be resignified with other levels of procurement; another technique, which seeks to revitalize the capacity of health care workers in defense of a health care model that values quality of care in a manner that is articulate, interactive, interdisciplinary and committed to the social determination of the health-disease process of people who require services in the SUS network.

The idea of connectivity is defended, valuing the specific knowledge of each profession, while establishing commitments to collective work. In summary, to provide comprehensive nursing care, it is necessary to recover the dimensions mentioned earlier: embracement, bonding, accountability and responsiveness to the demands of users and families, with ethical and social commitment. Nursing cannot exercise care that is disjointed from other practices and the organizational context of the health care system, at all levels of technological density in the SUS network.

These challenges point to possibilities of interconnection in the thinking about and deploying of health care, demarcated by policy, management, technical procedures and collective interaction in the act of care production. In this sense, health care practices, and in the case in focus, nursing, must have comprehensive care (individual or public) as the ultimate goal, operated by technological knowledge that values the relational field and intersubjectivity, entering into the world of the users' needs.

CONCLUSIONS

Health and nursing care practices persist with characteristics of the biological-based medical model, which is

mechanistic and centered on health care professionals, and emphasizes super-specialization, to the detriment of health care work that is able to grasp the broader needs of users and families, in a context which strives for comprehensive care.

This study reaffirms that the production of care must be the focus of all health care work, bearing in mind that intervention by technological action of each profession goes beyond the core of isolated knowledge, as is the case of nursing which, connected to other professional practices, can enter new territories of knowledge and practices that function by means of relational technologies. The field of relations is fundamental for the production of care that improves the health of users by means of light technologies⁽⁵⁾, in which intercessor relationships are established aimed at embracement, bonding and accountability.

Changing the way health care work is produced is no easy task, and an inversion of logic that has been operational to the present is needed. This should take place in the actions of all the subjects involved in the process (managers, health care workers and users).

Health services need to assume one of its most important tenets: to promote intervention focused on the user, without devaluing workers, that is capable of enabling autonomy of individuals in their way of living, without losing sight of the dimension of care that should be present in any act. It is through dialogue and negotiation, marked by intersubjectivity between worker and user, that it is possible to find ways to meet the needs set forth at this meeting.

Nursing is assuming significant spaces in care management, both at the micro and macro social levels. However, the spaces occupied have still not turned into spaces of change of practices, because the social determinations and historical contexts that influenced the way nursing exercised and exercises the care process cannot be denied⁽²⁾. The management model is bureaucratized, vertical, systematized in tasks and production of services.

Finally, challenges arise from new forms of organization of work in a modern and competitive world. Nursing needs to foster care that is more horizontal, seeking interfaces with other professionals and with other practices to rebuild its social role, seeking innovation and a balance among the technical, political and organizational dimensions.

REFERENCES

1. Pinheiro R, Ferla A, Silva Júnior A. Integrality in the population's health care programs. *Ciênc Saúde Coletiva* [Internet]. 2007 [cited 2013 Mar 03];12(2):343-9. Available from: <http://www.scielo.br/pdf/csc/v12n2/a10v12n2.pdf>
2. Fortuna CM, Matumoto S, Pereira MJB, Mishima SM, Kawata LS, Camargo-Borges C. Nurses and the collective care practices within the family health strategy. *Rev Lat Am Enfermagem* [Internet]. 2011 May-Jun [cited 2013 Mar 03];19(3):581-8. Available from: <http://www.scielo.br/pdf/rlae/v19n3/18.pdf>
3. Matumoto S, Fortuna C.M, Kawata, L S, Mishima, SM, Pereira MJB. Nurses' clinical practice in primary care: a process under construction. *Rev Lat Am Enfermagem* [Internet]. 2011 Jan-Feb [cited 2013 Mar 03];19(1):123-30. Available from: <http://www.scielo.br/pdf/rlae/v19n1/17.pdf>
4. Rocha SM, Almeida MCP. [The process of nursing work in collective health and interdisciplinary studies]. *Rev Lat Am Enfermagem* [Internet]. 2000 Dec [cited 2013 Mar 03];8(6):96-101. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/12041043> Portuguese.

5. Abrahão AL, Merhy EE. [Healthcare training and micropolitics: concept tools in teaching practices]. *Interface (Botucatu)* [Internet]. 2014 [cited 2013 Mar 03];18(49):13-24. Available from: <http://www.scielo.br/pdf/icse/v18n49/1807-5762-icse-18-49-0313.pdf> Portuguese. DOI: 10.1590/1807-57622013.0166
6. Assis MM, Jesus WL. [Access to health services: approaches, concepts, policies and analysis model]. *Cienc Saude Coletiva* [Internet]. 2012 Nov [cited 2013 Mar 03];17(11):2865-75. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23175292> Portuguese.
7. Amorim ACCLÁ, Assis MMA Santos AM, Jorge MSB, Servo MLS. Practices of the family health team: advisors of the access to the health services? *Texto & Contexto Enferm* [Internet]. 2014 Oct-Dec [cited 2013 Mar 03];23(4):1077-86. Available from: <http://www.scielo.br/pdf/tce/v23n4/0104-0707-tce-23-04-01077.pdf>
8. Alvarenga WA, Dupas G. Experience of taking care of children exposed to HIV: a trajectory of expectations. *Rev Lat Am Enfermagem* [Internet]. 2014 Oct [cited 2013 Mar 03];22(5):848-56. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/25493682>
9. Ferreira-Umpiérrez A, Fort-Fort Z. Experiences of family members of patients with colostomies and expectations about professional intervention. *Rev Lat Am Enfermagem* [Internet]. 2014 [cited 2013 Mar 03];22(2):241-7. Available from: <http://www.scielo.br/pdf/rlae/v22n2/0104-1169-rlae-22-02-00241.pdf>
10. Oro J, Matos E. Possibilities and limits of organization of nursing work in the comprehensive care model in a hospital institution. *Texto & Contexto Enferm* [Internet]. 2013 Abr-Jun [cited 2013 Mar 03];22(2):500-8. Available from: http://www.scielo.br/pdf/tce/v22n2/en_v22n2a28.pdf Portuguese.
11. Knight AW, Padgett J, George B, Dato MR. Reduced waiting times for GP: two examples of "advanced access" in Australia. *Med J Aust* [Internet]. 2005 Jul [cited 2013 Mar 03];183(2):101-3. Available from: <https://www.mja.com.au/journal/2005/183/2/reduced-waiting-times-gp-two-examples-advanced-access-australia>
12. Kopach R, Lawley M, Muthuraman K, Ozsen L, Rardin R, Wan H, et al. Effects of clinical characteristics on successful open access scheduling. *Health Care Manag Sci* [Internet]. 2007 Jun [cited 2013 Mar 03];10(2):111-24. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/17608053>
13. Starfield B. Primary care: balancing health needs, services and technology. New York: Oxford University Press; 1998.
14. Perez LG. Professional and community satisfaction with the Brazilian family health strategy. *Rev Saude Publica* [Internet]. 2013 Apr [cited 2013 Mar 03];47(2):403-13. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/24037368> DOI: 10.1590/S0034-8910.2013047003868
15. Jesus WL, Assis MM. [Systematic review about the concept of access to health services: planning contributions]. *Cienc Saude Colet* [Internet]. 2010 Jan [cited 2013 Mar 03];15(1):161-70. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20169243> Portuguese.
16. Carli R, Costa MC, Silva EB, Resta DG, Colomé ICS. Welcoming and bonding in the conceptions and practices of community health workers. *Texto & Contexto Enferm* [Internet]. 2014 Jul-Sep [cited 2013 Mar 03];23(3):626-32. Available from: <http://www.scielo.br/pdf/tce/v23n3/0104-0707-tce-23-03-00626.pdf> DOI:10.1590/0104-07072014001200013
17. Santos AM, Assis MMA, Nascimento MAA, Jorge MSB. Bond and autonomy of the oral health practice in the Family Health Program. *Rev Saude Publica* [Internet]. 2008 [cited 2013 Mar 03];42(3):464-70. Available from: http://www.scielo.br/pdf/rsp/v42n3/en_6189.pdf
18. Ayres JRCM. [Organization of health care actions: models and practices]. *Saúde Soc* [Internet]. 2009 [cited 2013 Mar 03];18(Supl 2):11-23. Available from: <http://www.scielo.br/pdf/sausoc/v18s2/03.pdf> Portuguese.
19. Salum NC, Prado ML. Continuing education in the development of competences in nurses. *Texto & Contexto Enferm* [Internet]. 2014 Apr-Jun [cited 2013 Mar 03];23(2):301-8. Available from: <http://www.scielo.br/pdf/tce/v23n2/0104-0707-tce-23-02-00301.pdf> DOI: 10.1590/0104-070720140021600011
20. D'Antonio P. Thinking about place: researching and reading the global history of nursing. *Texto & Contexto Enferm* [Internet]. 2009 [cited 2013 Mar 03];18(4):766-72. Available from: <http://www.scielo.br/pdf/tce/v18n4/19.pdf>