Original Article

Health needs of street market saleswomen: access, connection and welcoming as integral practices

Necessidades de saúde das mulheres feirantes: acesso, vínculo e acolhimento como práticas de integralidade

Necesidades de las mujeres de feria: acceso, enlaces y recepción como las prácticas integridad

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ABSTRACT

Objective: To analyze the health needs of street market saleswomen of the Mercado Público (Public Market) of a municipality in Northeastern Brazil.

Method: Qualitative, exploratory and descriptive study, with fifteen saleswomen in a public market. Data production means included semi-structured interviews, April-May 2016.

Results: Data were analyzed using the analysis of technical content technique, from which the following theme category emerged: "Access needs to health services and professional humanized practices." The women in the study highlighted the guarantee of access, connection and welcoming as driving practices for the recognition of health needs confronting the health-disease process and comprehensive care.

Conclusions: Being welcomed, identifying needs and producing a bond will contribute to these women recognizing themselves as subjects of their needs, strengthening their autonomy, empowerment and self-care.

Keywords: Health services needs and demand. Nursing care. Female work. Comprehensive health care.

RESUMO

Objetivo: Analisar as necessidades de saúde das mulheres feirantes do Mercado Público de um município do Nordeste do Brasil.

Método: Estudo qualitativo, exploratório-descritivo, com quinze mulheres feirantes de um mercado público. A produção de dados incluiu entrevistas semiestruturadas, de abril a maio de 2016.

Resultados: Os dados foram analisados mediante a técnica análise de conteúdo, emergindo a seguinte categoria temática: "Necessidades de acesso aos serviços de saúde e práticas profissionais humanizadas". As mulheres participantes do estudo destacaram a garantia do acesso, vínculo e acolhimento como práticas propulsoras para o reconhecimento das necessidades de saúde, enfrentamento do processo saúde-doença e integralidade do cuidado.

Conclusões: O acolhimento com identificação das necessidades e produção de vínculo contribuirá para que as feirantes se reconheçam como sujeitos de suas necessidades, fortalecendo sua autonomia, o empoderamento e o autocuidado.

Palavras-chave: Necessidades e demandas de serviços de saúde. Cuidados de enfermagem. Trabalho feminino. Assistência integral à saúde.

RESUMEN

Objetivo: Analizar las necesidades sanitarias de las mujeres puesteras de un mercado público en una ciudad del Noreste de Brasil.

Método: Estudio cualitativo, exploratorio y descriptivo, con quince vendedoras ambulantes de un mercado público. Los datos de producción incluyeron entrevistas semiestructuradas, abril-mayo de 2016.

Resultados: Los datos fueron analizados mediante el análisis de contenido técnico, emergiendo las siguientes categorías temáticas: "Las necesidades de acceso a servicios de salud y prácticas profesionales humanizados". Las mujeres en el estudio destacaron la garantía de acceso, vínculo y acogida como las prácticas de conducción para el reconocimiento de las necesidades de salud que enfrenta el proceso salud-enfermedad y la atención integral.

Conclusión: La acogida con la identificación de las necesidades y producción de vínculo contribuirá para que las puesteras se reconozcan como sujetos de sus necesidades, el fortalecimiento de su autonomía, el empoderamiento y el autocuidado.

Palabras clave: Necesidades y demandas de servicios de salud. Atención de enfermería. Trabajo femenino. Atención integral a la salud.

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INTRODUCTION

Street markets are predominantly synonymous with informal work, and is a place where female workers are also prevalent, representing a sizable portion of the poorly assisted population, even with highly vulnerable health related to the type of work activity they perform, and as one of its characteristics the variability of monthly income which ultimately leads to conflict, stress and disruption of the family network, reflecting negatively the health of these individuals[1].

The work developed by these market saleswomen presents difficulties, such as the extensive workload, which can reach eleven hours/day, with exposure to inadequate working conditions, like standing on end for a long time, moving from one side to another inside their boxes, not having pre-established schedules for meals and consuming those meals in the workplace between one customer and another. They also face economic problems due to having variable monthly income due to the autonomous nature of the profession.

This study addresses the health needs of street market saleswomen, their relevance is justified to the extent that these conditions may contribute to the emergence of diseases, emotional disorders, and lack of information about healthy living habits because of the difficulty to access health services, which also limits addressing the problem.

Because women's health is contemplated by public policies with specific health programs, actions are more focused on attention to pregnancy and childbirth, and the scale of their needs are not thought in basic health actions. The team has difficulties to understand the specifics of these health problems, the language and world view of these women.

It appears that research conducted with street market saleswomen concentrate more on entrepreneurship and gender focus at work. And, although there are studies on working conditions and street market saleswoman health[2-3], so far there hasn't been research that encompassed the health needs of these informal workers; research on how these people experience, think and perceive the world.

It is necessary to meet these needs, understanding the meanings of their nature at the intersection of the subjects involved, the moments of production and consumption of health to promote the autonomy of individuals, transforming current health practices and introducing new possibilities[4].

Thus, to meet the health needs through the uniqueness of street market saleswomen, comprehensive care is imperative. Adopting comprehensiveness as the axis of attention implies taking the health needs as a reference to arrange services and health practices. Thus, in the singular space of each health service, comprehensiveness could be defined as the health team's effort to translate and meet individual needs in the best way possible, identifying the singularities of everyone's necessities. The result of this "focused comprehensiveness" should be the result of efforts made by each of the workers and the team with its multiple knowledge and commitment to ever growing comprehensive care[5].

However, considering the progress made, comprehensive care does not yet happen as it should. The work of health teams is organized in a technicist and fragmented manner, focused on the disease, targeted to specific groups, not considering the health needs of individuals and lacking articulation of sectors of society.

Comprehensiveness will never be full in any given health service, as competent and committed as the staff is, or how effective communication between the workers and the coordination of their practices is. The battle for the improvement of living conditions and access to all technologies to enhance and prolong life, can never be fully successful in these health services. Comprehensive care brings us, then, to the macro dimension, i.e. attention as the result of an articulation of each health service, to a much more complex cross – sector network[5].

In this sense, health services need to begin changes and produce practices to stimulate and broaden the discussion and knowledge about the health needs of street market saleswomen, placing Primary Health Care (PHC) in a social process capable of instrumentalizing these needs. Similarly, it has the potential to assist health staff and nurses in moving towards a better proximity of reality, working conditions, and understanding of the meanings alluded to by the street market saleswomen, when considering the knowledge, cultural values and lifestyles, providing more closeness to the basis of their activities and contributing to the recognizing and addressing the health needs of this social segment whose needs are made invisible by formal health segments.

That said, this article was developed from the following research question: "What are the needs of street market saleswomen of the Mercado Público (Public Market) and how can those needs be met?" Therefore, the objective is to analyze the health needs of street market saleswomen of the Mercado Público (Public Market) of a municipality in Northeastern Brazil.

METHODOLOGY

The study consisted of an investigation with a qualitative, exploratory-descriptive approach. The theory of needs[6]

was used as a theoretical – methodological reference. In this approach, the needs are generated by continuous improvement of the historical stages and the dialectic of contradictions in each context is overcome by the transformation of society into new phases where needs are fully met.

Therefore, needs are unevenly materialized for individuals from different social classes and cultures, for unequal is the access to products that satisfy the needs. Thus, health needs are socially and historically determined, but the potential of individuals to modify themselves and their surroundings to qualify life, cannot be disregarded in this process[6].

A segment from an untitled master's dissertation: Life of Mary: Health needs of street market saleswoman of Public Market presented to Rede Nordeste de Formação em Saúde da Família (RENASF – Northeastern Brazil Network for Family Health Training), nucleation at the Universidade Estadual Vale do Acaraú (UVA)[7].

The research's setting was the Mercado Público (Public Market) in a city in Northeastern Brazil. At that location, 34 street market saleswomen are "coffee traders", and despite the name, they perform other activities in addition to selling coffee, such as selling meals and snacks to the public. Fifteen street market saleswomen who met the following inclusion criteria took part in the research: aged between 40-65 years old and working for more than five years in the activity in question.

Semi-structured interviews were conducted to produce data, ceasing when data saturation was identified. The interviews took place during the period from March to May 2016. The semi-structured interview was guided by a predefined script, outlining the object studied and contemplating timely issues that could bring out health needs such as: insertion at work, lifestyles, determinants of the health-disease process, concept of health, coping forms for health problems and effectiveness of health services to address the health problems of women in the study.

The women were identified in the transcripts of the speeches by the pseudonym "Maria", and to represent them, 15 names of Maria were used, public women who have left their stories of struggles and achievements recorded in the mind of the Brazilian people, from local women to those of national knowledge. The predominant age group was 40 to 49 years with varied education, and the majority did not complete elementary school. All had children, women prevailing as single parents and heads of the household.

Regarding data analysis, the expressions of the subjects on the objects of their health needs and their actions to qualify "the way of living life" were analyzed in a coherent sequence of thematic content analysis[8], which includes: pre-analysis, material exploration, treatment of results, inference and interpretation. The Taxonomy of Health Needs[9] was used as an instrumental to list and describe the needs perceived by the sample.

This taxonomy was built around four concepts: good living conditions; the need for access to health technologies able to improve or prolong life; the need to be welcomed and for an emotional bond between users and health care professionals and self-care in the way of "living life" [9].

This study met the ethical principles of research involving human subjects, in accordance with Resolution no. 466/12 of the Conselho Nacional de Saúde (National Health Council). All participants signed the Termo de Consentimento Livre e Esclarecido (TCLE – Free and Informed Consent Form) and the research was approved by the Ethics Committee of the Universidade Estadual Vale do Acaraú (CEP / UVA) under the Certificado de Apresentação para Apreciação Ética (CAAE – Presentation Certificate for Ethics Assessment) No 53306616.5 .0000.5053 and Opinion No. 1.450.354.

RESULTS AND DISCUSSION

The taxonomy of health needs[9] was used as an instrument able to list and describe submerged units of significance in the expressions of participants, representing their health needs. This taxonomy consists of four categories: the first brings the need for good living conditions; the second category refers to the need for access to health technologies able to improve or prolong life; category three includes the need for bonding between the user and the provider; and the last category, the need for autonomy and self-care in the way of living life.

This study was awarded a thematic category, whose contents reveal at all times the importance of the bond and welcoming, defined by women as a valuable tool in the process of meeting their needs.

"Access Needs to health services and humanized professional practices"

The study results showed that bonding and welcoming become essential strategies for ensuring access, recognition of health needs by the subjects and to meet their needs in relation to health services. These data converge with findings of other studies[10].

Women recognize that professional practices must be linked to the idea of humanized assistance, with recognition and use of soft technologies as important tools to satisfy their needs:

When we arrive at the health care center, having good service to take of use, we're Christian [...] We have to arrive and be assisted like we're customers, just like we attend to our customers. ("Maria Emma")

In the comparative figure used by the saleswoman, the health service user is as a street market client who buys products and the main rule is that they should be treated with respect and empathy, in addition to having their needs fully met and, if possible, overcome, for a satisfied customer is highly likely to return and generate positive publicity for their friends and family. The women also want to be treated as customers, who seek respect and proper care in health. It was interesting to identify that the idea of paying for health care is well developed among these women. After all, the state offers services that have been paid in advance through taxes as public and free, services defined as priority by the Constitution.

The term customer also highlighted the duality of the commercialization of health. On the positive side, it is worth noting the increased commitment of both the professional and the client with their care. However, simply changing the term does not imply a change of behavior, and one must be careful so that a negative view of the customer is not adopted, which can be of a simple individual consumer of the services offered by the State[11].

Empirical data show that previous experience assessed as positive by women favor the creation of a relationship with health professionals and satisfaction with the services provided.

[...] before when it was just Dr. X and Dr. Y in 2010, it was great, but now it's not good. We go there, and if you want to extract a tooth or fix a cavity, it takes 3 months. We aren't well attended there. Now we are, by the dentist assistant, but for others that schedule an appointment there are usually issues. ("Maria da Penha")

Considering this, having a professional or staff considered as a reference in accountability within the system becomes a necessity from the construction of the bond. The friendly professional posture conveys safety to the user and enables long-term relationships, facilitating longitudinality in comprehensive care [12]. In the case mentioned, the confidence that the market saleswomen had in the professionals contributed to strengthening relations and favored adherence to the actions and conducts, producing a unique work for the health needs of each individual.

In this context, the nurse is highlighted as a leader in health teams, and may point out changes in practice to the team, favoring the humanization of care. Humanized nursing care is fundamental to the saleswomen, because the interaction between technical and scientific knowledge with the emotional, social, cultural and ethical aspects in the relationship between the professional and the user ensures greater service efficiency, preserving and maintaining living conditions and promoting the recovery of these[13].

In addition, the creation of bonds between users and staff and/or health care professional, also part of the set of concepts involving the health needs, which means the establishment of an ongoing relationship that continues to be warm, personal and not transferable, which provides the encounter of subjectivities[5].

Frequent clashes between the proposal of the Family Health Strategy (ESF) and the demands of users are also present in some discursive constructions. This type of discourse refers to women who vigorously claim the right to be served, aggressively expressing their demands while others react passively and don't express their needs:

Sometimes we come in with a slight problem and then what happens? Nothing happens, you just wait, wait, wait. Once I had a problem and went to the health care unit and then what? I even had to make a scene for them to finally consult me. I was pretty rough on them because they don't want to provide care for us. ("Maria Rita")

What we really need we don't have: good service [...] we're human beings, it seems the higher the staff's education level, the worst the service. We are totally neglected. And the girls also say that, if you arrive there making a scene it's easier to get service [...] So I said that if I have to be consulted making a scene everywhere I go, that's not for me, if I am consulted, then I am, you know? ("Maria Clara")

The discourses show complaint and individual indignation but not a discourse of collective participation in prioritization and a search for everyday problem solving in organizing health care services. The way health care production is organized, confined to service rooms, hoping that sick people show up and take medication is what contributes the population's passivity.

From this perspective, it is noteworthy that the procedure-centered model as opposed to the user-centered, desired model, appears to be the critical barrier. On the one hand, the lack of commitment of workers and management with people, treating them only as a disease; secondly, disabled people feel they are in an asymmetric relationship, reason for which they are silent [14].

Thus, within this structure, some women have few opportunities to recognize their health needs and position as subjects in the health/disease process. There seems to be a strong connotation that the individuals do not see themselves as subjects of a political process to fight to guarantee their rights as a citizen.

> *For things to change, we have to be more valued by the rich, the mayor [...] especially the people of the health care center, because when we need them, they all turn their backs [...] the governor needs to look out for us more. They give out bolsa familia, it's useless, they give to some and not others. ("Maria Emma")*

The street market saleswoman is not recognized as a social protagonist that claims and discusses her demands seeking to meet her needs. Rights are recognized only as a gift, and there is no awareness regarding the need to fight to conquer them.

In this sense, right that are essential to the human person are considered historical, changeable and susceptible to transformation and expansion. Rights emerge from the struggles against old powers, the struggles against oppression, against excesses in defense of new freedoms. Therefore, they are not all born at once, but when the conditions are favorable for this process, and when they are recognized as a need to ensure every individual and society a dignified existence [15].

In the reality of health care services, there is great difficulty among professionals of ESF and nurses to mobilize and encourage people to build and organize health care together. It is vital to establish bonds and dialog, meeting the subjectivity of each individual, their culture, their beliefs, values and history.

The following report shows the need for greater flexibility in service and mentions obstacles in the organizational accessibility of health care resources, such as the waiting time to be consulted by the medical professional:

> *We arrive at the health care unit and we have to run all around the place. It takes centuries for them to send us to the doctor. ("Maria Firmino")*

The waiting time was evaluated in other studies in Brazil and the results are usually negative, pointing out difficulties in quickly accessing services, which may negatively impact on the user's assessment of the service, in particular regarding the resolution of acute or subacute complaints[16].

In this sense, it should be noted that the moment of consultation is central to the diagnostic and therapeutic process, being necessary to the understanding of the individual's subjectivity and influence on psychosocial, cultural, religious clinical aspects. The duration of the consult, the user-centric model should allow time to address: the professional agenda related to symptoms and disease; the user schedule that includes their concerns, fears and experience of becoming ill; and integration between the two[17].

Thus, for the work process to be reorganized, it is essential to implement the welcoming process, with qualified listening and efforts to provide a positive response that responds to the user's needs.

However, this response cannot always be considered positive by the user, because often they go to the Basic Health Unit (UBS) seeking an immediate response. As this is not always possible, often the answer can be an orientation or referral to another service. Even if the service is not immediate, or not exactly what the user was seeking, the goal is for users to be heard, accepted, to have the opportunity to understand the reason for such a response and to have his or her demands answered[18].

In this case, it is possible to infer that women seek health services, but are faced with difficulties of access arising from organizational accessibility, a negative representation of health services which interferes with adherence to treatment for street market saleswomen. What the discourses reveal is that there is still a significant lack of access to health services, which primarily affects poor and dependent women in the public system, proving that at least in terms of universality and equality, the Unified Health System (SUS) still under delivers.

> *[...] when I try to schedule a pap smear, the machine is usually broken or something else happens and we just give up. And we cannot afford to pay a private consult. And just like that, everything is difficult. ("Maria Emma")*

There are inequities in access and inefficiency in the health system regarding users of SUS. The ratio of supply and demand for health services is the result of clashes, conflicts and contradictions, as they do not only consider the health needs of users, but depend on the organizational determinants such as cost, accessibility and manpower. This organization usually does not occur in a way to prioritize the demands and needs of the community, but is determined by the services provided by health facilities, without putting the user at the center of the work process[10].

Thus, it is understood that the principles of equity and universality are not being implemented as they should, resulting in socio-economic losses. Thus, there is a contradiction between what is provided for in the NHS and what

happens in the daily life of the service users. There is still a wide gap between the health needs of the population and public actions and health services. These authors point out that the organizational processes of SUS, to date, move between the decentralization that fragments the services and regionalization that should unite them in an integrated and referenced network able to give objective answers to the problems demanded by users[19].

Another difficulty of access to health services listed by the street market saleswomen concerns extensive working hours, which is recognized as a barrier that impedes access to professional health practices, helping to not exercise proper care of themselves. The organization of primary care health services meets the service hours that coincide with business hours, during which the women of the study work. On the other hand, the organization of consults, by appointment, with little space for spontaneous demands, makes access more difficult for this population.

> *It takes time, and that's what we do not have is time to take care of our health. ("Maria Rita")*

> *It depends on our availability, right? Because sometimes they don't have time, they're too busy and then when they finally get to the doctor they're already very sick. ("Maria Quitéria")*

> *The time we have to be here isn't enough to run after doctors, we work all the time. ("Maria do Carmo")*

health services, especially primary care, should offer attention without making demands about availability, also providing care at times that are do not coincide with business hours; facility to schedule consults and reduction in waiting periods, facilities for the disabled and lack of language and cultural barriers [20].

It should be noted that health professionals, especially nurses must be aware of their power to induce demands. The flexibility of working to provide access for to a warm welcome and the availability of compatible schedules for workers reduces other barriers, and can also mean opportunities for professionals to build bonds with the street market saleswomen, respecting their autonomy "in the way of living life", meaning, therefore to provide care.

CONCLUSIONS

This study made it possible to know the contradictions and difficulties faced by street market saleswomen when seeking health services, and highlighted gaps in the service, the promptness, quality of demands and responses, with consequent obstacles to access to and use of existing technologies. It also reiterated the lack of appropriate bonds between women and health professionals, even after they seek primary care and recognize its use in some way.

Women considered the welcome and bond as elements of value in the care process, pointing to the importance of the meeting between professionals and users with qualified listening, attention and more proximity to reality, leading to the development of practices for the recognition this public's health needs in an integral way. However, for these practices to be effective, practitioners should be familiar with the daily life of these women, the labor activity they undertake and the implications that "being a street market saleswoman" brings to self-care. To question this reality, clearly define the health needs and seek resources that will enable the adoption of measures that will contribute to improving the living conditions of these people.

Given the above, this study may contribute to research, teaching and nursing care, as it raises thoughts on the need for changes in health practices of nurses, to contribute to the distancing from social reproduction of medication promoting cultures and unveiling paths to a practice that recognizes the need for the autonomy of the subjects.

Despite a considerable number of participants, considering the current context, the fact that the study was conducted in only one public market is seen as a limitation. It is expected that the study will contribute to provoking questions and directions, providing possibilities for continuity and studies to deepen this field to understand the practices of professional nurses and their purpose in translating and meet the health needs street market saleswomen, further comprising the issues involved in the social recognition of these needs.

REFERENCES

1. Lima KS, Almeida AM. O conhecimento de feirantes sobre a hipertensão arterial e suas complicações. Rev Baiana Saúde Pública. 2014;38(4):865-81.
2. Carvalho RG, Oliveira IA, Maia LM, Maciel RH, Matos TR. Situações de trabalho e relatos de dor entre feirantes de confecções. Rev Psicol Organ Trab. 2016;16(3):274-84.
3. Silva SRA, Amorim RC, Almeida AM. Percepção de feirantes hipertensos sobre o adoecer crônico. Rev Enferm UERJ. 2015;23(6):761-6.
4. Moraes PA, Bertolozzi MR, Hino P. Percepções sobre necessidades de saúde na atenção básica segundo usuários de um serviço de saúde. Rev Esc Enferm USP. 2011;45(1):19-25.
5. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade na atenção em saúde. In: Pinheiro R, Mattos RA, or-

ganizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: UERJ; 2001. p. 39-64.
6. Heller A. Teoría de las necessidades em Marx. 2. ed. Barcelona: Península; 1986.
7. Magalhães AHRM. Vida de Maria: necessidades de saúde das mulheres feirantes do mercado público [dissertação]. Sobral (CE): Universidade Estadual Vale do Acaraú; 2016.
8. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
9. Cecílio LCO, Matsumoto NF. Uma taxonomia operacional de necessidades de saúde. In: Pinheiro R, Ferla A, Mattos R, organizadores. Gestão em redes: tecendo os fios da integralidade em saúde. Caxias do Sul: EDUSC/UFRS; Rio de Janeiro: IMS/UERJ/CEPESC; 2006. p. 37-50.
10. Souza MC, Araújo TM, Andrade FA, França AJ, Souza JN. Necessidades de saúde e produção do cuidado em uma unidade de saúde em um município do Nordeste, Brasil. Mundo Saúde. 2014;38(2):139-48.
11. Saito DYT, Zoboli ELCP, Schveitzer MC, Maeda ST. Usuário, cliente ou paciente? qual o termo mais utilizado pelos estudantes de enfermagem? Texto Contexto Enferm. 2013;22(1):175-83.
12. Queiroz ES, Penna CMM. Conceitos e práticas de integralidade no município de Catas Altas-MG. REME Rev Min Enferm. 2011;15(1):62-9.
13. Chernicharo IM, Freitas FDS, Ferreira MA. Humanização no cuidado de enfermagem: contribuição ao debate sobre a Política Nacional de Humanização. Rev Bras Enferm. 2013;66(4):564-70.
14. Merhy EE. O conhecer militante do sujeito implicado: o desafio de reconhecê-lo como saber válido. In: Franco TB, Peres MAA, organizadores. Acolher Chapecó: uma experiência de mudança do modelo assistencial, com base no processo de trabalho. São Paulo: Hucitec; 2004. p. 21-45.
15. Bobbio N. A era dos direitos. Rio de Janeiro: Campus; 2004.
16. Sala A, Luppi CG, Simões O, Marsiglia RG. Integralidade e atenção primária à saúde: avaliação na perspectiva dos usuários de unidades de saúde do município de São Paulo. Saúde Soc. 2011;20(4): 948-60.
17. Comes Y, Trindade JS, Shimizu HE, Hamann EM, Bargioni F, Ramirez L, et al. Avaliação da satisfação dos usuários e da responsividade dos serviços em municípios inscritos no Programa Mais Médicos. Ciênc Saúde Coletiva. 2016;21(9):2749-59.
18. Barra SAR. O acolhimento no processo de trabalho em saúde. Serv Soc Rev. 2011;13(2):119-42.
19. Santos L, Andrade LOM. Acesso às ações e aos serviços de saúde: uma visão polissêmica. Ciênc Saúde Coletiva. 2012;17(11):2876-8.
20. Starfield B. Atenção primária: equilíbrio entre necessidade de saúde, serviços e tecnologia. Brasília: UNESCO, Ministério da Saúde; 2002.

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