

APPROACHING HEALTH NEEDS IN THE ASSISTANCE ENCOUNTER OF WORKERS AND USERS ON FAMILY HEALTH¹

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ABSTRACT: Qualitative and descriptive study held in Cuiabá, Mato Grosso, Brazil, aiming at analyzing the approaching of health needs from users in the assistance practice of the family health. It was adopted a socio-historical reading about health practice and needs that values interface with intersubjectivity. The present study was performed in one unit through participative observation, semistructured interviews with 8 workers and 17 users, and the analysis of the empirical theme content. Amid the clash of different logics governing the family health, the needs approaching is characterized by a selective process, through the application of various retainers, accompanied by countless tensions and conflicts involving the staff and/or users, and strategies to maintain the control or expand the access for needs answer. This study points out the importance of the subjects in assertion, confrontation and/or relaxation of what it was established, shaping possibilities of a comprehensive or reduced approach about health needs.

DESCRIPTORS: Family health program. Health services needs and demands. Work.

ABORDAGEM DE NECESSIDADES DE SAÚDE NO ENCONTRO ASSISTENCIAL DE TRABALHADORES E USUÁRIOS NA SAÚDE DA FAMÍLIA

RESUMO: Estudo qualitativo, descritivo, realizado em Cuiabá, Mato Grosso, Brasil, objetivando analisar como ocorre a abordagem de necessidades de saúde de usuários na prática assistencial da Saúde da Família. Adotou-se uma leitura sócio-histórica da prática e das necessidades de saúde, que valoriza a interface com a intersubjetividade. Realizou-se o estudo em uma unidade, através de observação participante, de entrevista semiestruturada com oito trabalhadores e 17 usuários, e da análise de conteúdo temática do empírico. Em meio ao confronto de lógicas distintas que governam a Saúde da Família, a abordagem de necessidades é caracterizada por um processo seletivo, viabilizado pela aplicação de diversos contêntores, acompanhado de inúmeros tensionamentos e conflitos envolvendo a equipe e/ou usuários, e de estratégias para manter contensões ou ampliar o acesso às respostas das necessidades. Evidencia-se a importância dos sujeitos na afirmação, confrontação e/ou flexibilização do estabelecido, moldando possibilidades de uma abordagem abrangente ou reduzida de necessidades de saúde.

DESCRIPTORES: Programa saúde da família. Necessidades e demandas de serviços de saúde. Trabalho.

ENFOQUE DE LAS NECESIDADES DE SALUD EN EL ENCUENTRO DE ASISTENCIA DE LOS TRABAJADORES Y USUARIOS EN LA SALUD DE LA FAMILIA

RESUMEN: Estudio cualitativo, descriptivo, efectuado en Cuiabá, Mato Grosso, con el objetivo de analizar como se procesa el enfoque de necesidades de salud de usuarios en la práctica asistencial de la Salud de la Familia. Se adoptó una lectura social e histórica del proceso de trabajo y de las necesidades de salud, que valora la interrelación con la intersubjetividad. El estudio fue realizado en una unidad, a través de observación participante, entrevista semi-estructurada con 8 trabajadores y 17 usuarios, además de análisis de contenido temático. Se identificó que debido a la confrontación entre lógicas diferentes que gobiernan la salud de la familia, el enfoque de las necesidades es caracterizado por un proceso selectivo, a través de algunos retentores, acompañado por innúmeras tensiones y conflictos involucrando miembros de equipos y/o usuarios, y por enfoques de afirmación de lo establecido y/o de ampliación de la aprensión de las necesidades. El estudio demuestra la importancia de la participación de los individuos en la reafirmación, confrontación y/o flexibilización de lo establecido, moldeando las posibilidades de un enfoque más o menos extenso de necesidades de la salud.

DESCRIPTORES: Programa de salud de la familia. Necesidades y demanda de servicios de Salud. Trabajo.

INTRODUCTION

This article discusses the practice in the Family Health (SF) and focuses on the welfare approach for users' health needs. It is studied how workers perceive, refuse and/or respond to them, in the assistance encounter with users and the way they realize their participation. Users are also considered in their expressions of needs and ways of thinking about the matter.

The process of working in the SF corresponds to the intentional and transformative collective practice of their workers, directed to the territorialized users and their health needs. They were seized by professions/jobs through knowledge, values, actions, relationships and other means of management, assistive and organizational features. In this process, cut, apprehension and satisfaction of needs are guided by work purposes socially prioritized.¹

These goals are affirmed, delimited, enlarged or opposed in the practice. So, the users and workers with interests, experiences, ideas, values, autonomy or not, shape the intersubjective conditions of work. Possibilities, wills, ways to address and ethical perspectives integrate the aims, the work itself and give directionality to them,² influencing the interactional and socio-technical approach of health necessities.

In the SF, as in other health jobs, the technological stage of the transformation process/satisfaction of health needs interfaces with the interaction, which comprises a relational dimension, communicative and ethics, articulated to the first one,^{3,4} that is to say, practice in the SF is guided by a technical rationality, while it is effective through an important intersubjective dimension.

From a Marxist view⁵⁻⁶ the users health necessity (individuals and collectives) corresponds to what it needs to be satisfied to preserve the life, develop human potentials (among them the ability to create and freedom) and overcome shortages of organic, psychological, socio-cultural, physical and environmental nature, related to the existence in concrete contexts. These are needs that, once met, guarantee or produce health, according to social and intersubjective parameters about what compose them.^{1,7}

Thus, the issue requires workers attention, on its mode of presentation in everyday life, the way they are apprehended or rejected and how to answer them, since, according to social interests, objective and subjective conditions many of

them are hidden, restricted or denied, created and stimulated, and they are treated without taking into consideration the conditions that generate them, producing more or less health.⁷

Currently, the approach on needs in the health sector care is in the context of the biomedical assistance model, and there are new construction projects, such as the SF that is nationally proposed for remodeling the primary care. In the model of prioritized health, the approach on health needs has been limited and, to some extent, decontextualized. However, the SF objective is a broad and contextualized apprehension, although the health sector/primary care is not solely responsible for this complex task.

The effectiveness of this new project is sustained, among other things, understanding the agents that comprise the health work, despite being guided by the prevailing logic, may dialectically recreate spaces, resources and processes to broaden the approach of the health needs.⁸

By considering the importance of the topic, it is identified that there are few researches that address it specifically⁹⁻¹² and its relation to healthcare practice in the SF,¹³⁻¹⁶ and that mobilizes the study presented here. It seeks to answer the following question: what possible ruptures and continuities are there in the way to deal with necessities in the assistance meeting of the SF, by considering the socio-historical and intersubjective meaning of the health practice?

This study aims to examine how the profile and the incorporation of users' health needs occur in the care practice of the SF team, focusing on the assistance meeting between workers, users and their perspectives about the matter.

METHODOLOGY

This is a descriptive and exploratory research with qualitative approach, conducted in a Family Health Unit (USF) in Cuiabá, Mato Grosso,¹⁷ and it was chosen from: 1) institutional definition about the area and priority services to the investment on education and research; 2) characteristics of the USF, like implementation time greater than 2 years and the existence of a complete health team; and 3) access to the researcher.

The selected unit, at the time of data collection, was composed by the minimum team required by the Ministry of Health. The user (individuals and families) was the resident regis-

tered in the coverage area. Care actions comprised primarily: medical and nursing consultations, un-systematic and group educational activities, home visits, specific actions of supervision, nursing procedures and laboratory exams. The work was centered on demand attention and strategic actions (prenatal of habitual risk, control of hanseniasis, tuberculosis, diabetes and hypertension, monitoring child development and growth, preventive care for cervical and breast cancer). The user's flow in the unit was organized through initial contact of the user with the USF; entry via reception and pre-consultation; medical care, nursing care, access to nursing procedures, medicines and/or other resources; scheduling and/or referral to other services; and exit/return.

Data collection was conducted between April and June 2009, totaling 190 hours. It was used the techniques of participant observation and semi-structured interview.

It was observed: 1) the initial contact between the user and the service; 2) the reception; and 3) offering-consumption of various procedures, pre-and post-consultation, medical and nursing consultations, educational activities and home visits. It was considered: people involved, the person who mobilized the encounter, the way relationships were established, specific health needs, refused and/or received, care actions and reactions of the people involved. For the record, it was used the field diary. It was followed up on his performance: a doctor, two nurses, three nursing technicians, a receptionist, six Health Community Workers (ACs), a typist, two general service workers and four guards. It was observed the participation of the users in the accompanied assistance encounters.

The interview covered issues relating to the participants identification, perceptions of health needs and their approach by the service. Eight workers participated in the study and they were elected due to their central role in addressing the needs: two nurses, two nursing technicians, two ACs, a receptionist and a physician. Also, 17 users participated, and in the encounter with the service, they presented important elements to achieving the objectives of the study, which were identified after initial analysis of the material collected through observation.

In relation to data, it was used the analysis of thematic content. It was performed vertical, horizontal and transversal reading of the material, from the research question detailing, considering

user demonstrations, team practice on addressing needs and interactions among individuals. The required legal and ethical aspects were respected. The research was approved by the Committee of Ethics in Research - CEP/HUJM - Opinion number 559/7 HUJM/8.

RESULTS AND DISCUSSION

Selection of health needs before the contact between the user and the SF

Before showing how the SF studied team addressed the needs in the assistance encounter, it is possible to highlight the necessities selection prior to the user contact with the unit. The existing actions in the SF, other health services and how the assistance was performed on them interfered in the users' interpretation about health needs, identification and pursuit of the USF, and also, in the expression of needs.

This identified aspect is evidenced in reflections on demand and use of health services by the users, which stresses among other things, implications of supply and quality of the health services in the process. In the face of attributes about the health units, they are not always viewed as alternatives to be used, and health necessities are not always identified or turned into demands.¹⁸⁻¹⁹

The demand expresses the translation of the user about health needs and the responsibility of the health service before them, because they represent an explicit request for assistance.²⁰ This demand is modeled by several factors, including: offering and quality of social/health services; the experience of a particular need and its influence in life; socio-cultural and subjective problems, and the value that the user assign to the service/procedure regarding satisfaction of necessities.¹⁸⁻¹⁹ Therefore, the use and search for health services are conditioned by several related factors: context, users and employees; health policy, services organization, performed practices and health needs.

In this study, it was identified that certain peculiarities concerning care quality and organization, in the SF, are important and anticipated tests on the needs expression of users' health. For example, distance between the user's residence and service facility; difficulty of access to medical consultation immediately, at the moment the user interprets that he needs it; previous experiences

with the staff considered as negative ones, usually associated with lack of response to the problems faced and conflicts in relationships, among other matters. Then, certain characteristics of the SF (access, resolution and interrelationships), from the user perspective, promote in advance the selection of health needs.

It is noted that even before establishing the care encounter a significant portion of the territorialized population will not seek needs responses in the SF or will not express them in this space, among other reasons, due to characteristics of the organization and relations present in the work.

Selection of health needs in the care encounter between the user and the SF

After transposing the anticipated test, the user, when looking for the local service, will try to confirm his entry in it, although he has no assurance: first, that he will be attended; second, if he is attended he will have space to canalize his needs as they were experienced/interpreted; and third, his needs will be attended with the participation of workers, resources therein or in other areas.

It is possible to mention that in the assistance encounter at the SF occurs a new and important selectivity of needs, which is related to priorities and actions performed in the service to its approach and the present intersubjectivity about the topic.

With regard to the users and before their needs, it was observed they have knowledge, information and values about the SF, and they are anchored in their experiences: on available actions, if they serve for them, who is available to perform those actions and when. From there, they judge if there is a possibility of attendance or not; they accept it or not, and they express that or not according to the needs on different assistance moments of entry and exit.

Accordingly, the users have certain representations about health needs and the approach for services and/or outside them. So, certain needs are perceived and expressed, or not, as "a problem" lived and a health issue to be addressed with the help of the service and health worker from whom they await a response.¹⁸

The workers of the SF also have knowledge, values and feelings about the topic, which are also anchored in their experiences and amid the concrete conditions of work. They also give direction to the way they perform the user's approach:

recognition and apprehension of needs, things they refuse and responses they provide. Workers do not always consider, through their interpretations and actions, what users expect, present and need. In their actions, there is a strong influence on what is valued in the assistance organization of the biomedical model, even though they have some "self-government"⁸ that provides the flexibility of the established norms, and favors a closer approach than expected by the users.

In the analyzed unit, the presentation of user needs and their approach by the workers were immediately correlated to the priorities of the service and both parts considered as service responsibility, especially relating to the medical care, since it was the core of the matter. The valued actions in the SF, which were strategic and medical care to the demand, guided the search for users and its needs presentation, as well as oriented the workers about what they would consider and through which alternatives. Consequently, users' demands were usually articulated for medical consultation, and workers' responses were structured heavily around this, its availability, its limits and possibilities of transposing them with internal and/or external resources to the service.

When users' needs were expressed at the care encounter, and accepted by the SF due to some attention, did not mean that all of them would be provided. Sometimes, it was found some needs included in the priorities of the SF (like medical assistance) were refused or generated new demands, new flows and other measures within the unit and other public or private services.

Still, it was identified that some needs were often rejected in the assistance approach related to the whole life, such as family conflicts, difficulties in maintaining family income, psycho-emotional distress, among others. Even those expressed by the users, especially to the workers they had higher bonds with or recognized by them as directly related to health and disease.

It is historically known that in health services these needs are naturalized, disregarded and/or simply assigned to other professionals and sectors.⁷ The naturalization of these health needs and their approach are factors that favor the selectivity about care approach in various moments of the encounter, despite their expression by the users and what they mean. This naturalization is characterized particularly in non-recognition by the worker and population itself, of the significance on social and ethical meaning of the service prioritizations

and its articulation to the biomedical logic that is present in the SF.

Mobilization of retainers, tensions and conflicts on the approach of health needs in the SF

Among other reasons, due to some service failure analyzed in relation to the provision of medical consultation around which main demands revolved to contain them, the workers involved with the process of entry and reception of users (guard, receptionist, nursing staff, and nurse) mobilized rules for access organization. These rules, at the time they institute that, operated as health needs retainers and promoted its selection.

The mobilized rules covered certain defaults, commonly applied to: the timing of the appointments (for example, being a resident of the covered area and registered in the unit), the existence of "slots" in the medical consultation (like presenting signs and/or symptoms such as high blood pressure, fever, vomiting, diarrhea and/or precordial pain), and around definitions generated from medical care.

These rules were applied especially in the reception area, where it was usually manifested tensions and countless conflicts (resulting from efforts or actions taken by users in order to break the limits imposed by the service in the health needs approaching). In other sectors, when the authorization for medical consultation was already "guaranteed" or in situations where the user did not require it, tensions and conflicts were smaller or non-existent.

The reception is traditionally considered as a place of continuous tensions and conflicts. On the one side, the user with a demand believes he must be attended by the service, on the other hand, there is a worker who is responsible for the user and answers to his needs, but he acts restricted by the existing alternatives at the service.²¹ In addition, the subjects act in interested ways in relation to health, that is, according to their projects and interests (of a group and/or person). Therefore, care encounter is a place of permanent tension since there is contact between different desires, interests and they are not always common ones. Moreover, all those involved in the production of health perform certain government, given the degree of freedom that exists in health daily life.⁸

The study showed that tensions and conflicts found between workers/users and workers/workers were normally related to the service organization at the SF, and how people involved dealt with the following provisions: limits about access, application of norms, the attempt to break these norms and their flexibilization.

According to the users, difficulties of access to the SF were related to organizational aspects that appeared immediately before them, such as: insufficient number of physicians and vacancies for consultation; mismatch between the assistance unit schedule and immediate needs they had; time for consultation scheduling considered inappropriate; lack of resolution about their problems or lack of assistance guarantee.

The workers were demanded by users because of access difficulties, failures in care continuity and lack of resolution. But, they claimed to do their part, developing the necessary and possible actions within the SF. For them, difficulties were associated to the organizational aspects of the service, relating mainly to the lack of support from the health municipal service, such as: shortage of specialized physicians in the network; lack of psychologist and social worker in the SF team; reduced offering of dental assistance; poor service infrastructure; excessive bureaucratic demands of work, among others. Moreover, they considered that in the final production of assistance, in the SF, (and, therefore, in response to the needs) influenced the lack of teamwork, the users passivity and their small participation in the service definitions.

Workers acknowledged their participation in the needs approach, but before the limits and problems experienced, they evidenced especially the aspects of practice organization in the SF. They cited the human component accustomed to addressing needs. They considered that the intense routine work, which generated some suffering, hindered a committed practice to the comprehensive approach of health needs. They considered themselves as individuals with needs and care dependent.

In the studied service, workers made use of several strategies in order to maintain the established aspects, to address/confront certain users' demands and even tensions and conflicts. Among them: continued assertion of rules; denial on the expressed by users, judgmental and/or punitive measures about them. Often, it was realized that users tried, somehow, to ensure access

to what they considered as necessity, and they attempted to break the established rules. Because of that, sometimes, workers not only affirmed the rules, but also issued judgments about the users' behavior and blamed them for the problems. This way, it was justified the lack of care about expressed needs.

There was also a double position of the workers in relation to the rules. Although these rules were applied to many users without considering any singularity, including punitive ways for some of them, they were also eased depending on who the user was (his proximity to the worker) and judgments about the user and his needs.

Thereby, this is the way the logic of the work focused on medical action becomes associated with the provision of certain assistance possibilities, accompanied by several modes of health needs containment, tensions and conflicts that are present in their approach amid the restrictions. The organizational and intersubjective elements present in the "opening" for certain needs or their "containment", involving users and workers, functioned as networks continuously stressed, more or less inflected by the model/service planning and actions/ reactions-relationships of the people involved. These networks influenced the opening of service/workers to the needs and their selection.

Strategies to expand the approach of health needs adopted by workers and users in the SF

Although the organizational logic of the SF exerts great influence on users' needs approach, their form of participation along with the workers gave specificity to its contours, in the care encounter. In other words, the present network of contentions tried to guarantee an approach considered compatible with social objectives prioritized to the SF. However, this network was more or less relaxed to depend on the people involved in the encounter, the characteristics of interaction and subjects' modes of placing that, even without breaking the restrictive medical logic, enabled an approach more or less comprehensive of needs.

In the analyzed unit, the people who worked at the entrance and reception, especially from a practical wisdom (though it was not only that), interfered to some extent in the "established" norms by redefining and/or including more favorable modes of dealing with the issue in focus.

At the care encounter, and mediated by some relationships, workers of the SF exercised some autonomy in their possession and, based on various elements, made decisions more or less favorable to the incorporation of health needs and responses for them. The work project they had in mind directed the applied cutting of needs: valued needs, effective interrelationships between team and users, and also, ethical positions assumed.

It was possible to identify some situations in which the worker pictured, urged the expression and apprehended health needs that were not indicated by the user, or through a good interaction and clinical approach he provided the expression of new needs, although linked to the biological dimension.

It was also realized that in order to extend the needs approach, in situations where the contention might have been the correct answer, workers used the mediation/negotiation along with other local workers, especially physicians and nurses. They also tried to facilitate the response to the family, community and workers from other services. Sometimes, it was performed through friendship relations, since there was no back up guarantee in the social service.

The users also applied several strategies in order to break contentions and, consequently, expand the access for assistance in the SF, and the responses to health needs. One of them was the reaffirmation of demands at the reception, in relation to certain established justifications, strategies for convincing the worker to revise the rules and/or measures of negotiation with him, in addition to direct and indirect pressures. They also took advantage of different interaction moments with professionals to expose new required needs that were different from the ones that generated the treatment, what happened in the triage, hallway, pre-consultation, medical and nursing consultation, home visits, among other spaces.

At the consultation space, the user also seized the moment to present needs of the person who accompanied him or required assistance for other family members, in an attempt to widen the consultation access. Sometimes, the user not only had complaints, but also demanded certain technologies that constitute necessities, suggesting the professional a conduct interpreted as the most suitable to his case.

It was identified that the way to relate and bond established between workers and users

was decisive in the accountability of both and the expansion of needs approach, in other words, facilitating the access and feasibility of appropriate responses to the needs.

Thus, this study allowed to realize that the technological dimension of work in its interface with the human dimension or interaction is essential to the enhancement of a practice at the service of users' health needs in the SF, and more opened to overcome the selective character that is present in it.

The mediation practice of the ACS in the expansion of needs approach at the SF

As an important link to the approach extension and response to the users' needs, it was found the ACS practice, which through its experience in the areas of health could capture important elements of its residents' life context. These users characterized their health needs, made them alive and canalized them to the service.

Study conducted in the municipality of São Paulo, between 2007 and 2008, aiming to meet instruments used in the recognition of health needs of the population in the SF. It points out the ACS as the primary team member responsible for needs assessment, and using the home visit as an important tool.¹⁵ This is considered by the families as important means of responding the experienced needs.²²

In the present research, it was realized that the ACS, while participating in the contention actions, commonly led to the service some needs that traditionally "do not fit" the established norms and, thereby, it mobilized its "order" promoting tensions and conflicts in the team work, too. In other words, with its action, the ACS has actively participated in the formation and relaxation of networks that influence the opening and selection of needs made by the service/workers.

The proximity with the users and their contexts places the ACS in a position of better understanding another order of necessity: the needs related to the living conditions and family processes. Nevertheless, it also tries to maintain a good relationship with users, answers the revealed demands and needs discovered, among other reasons, because of its responsibility and/or identification with the situations related to its insertion in similar conditions.

The presentation of the users' needs made by the ACS to the service, with the important characteristics according to other workers, broadened its contact with the health needs and contributed, to some extent, for the understanding expansion and responses to them.

FINAL CONSIDERATIONS

Through the corroboration of studies that show the importance of a broad approach about health needs, and discuss the problem by considering its relation with the modeling dynamic, interactive and communicative dimension of the health work, this research explains some ways to approach health needs, which are present in the SF, involving aspects of the service organization and action-relation of the subjects.

The approach of needs finding has revealed a bottleneck process or selection, which restricted them to the prioritized biomedical aspects, favored by many retainers of needs: offering and systematic care, norms, routines, controls, pieces of information and obligations, among others. That is, the selection of needs anchored on various elements of the local service organization, which held its logic centered in the medical work and had an important representation in the workers' action.

Since it was against interests and established norms, the needs selection was sometimes followed by major tensions and conflicts involving workers/users and/or workers among themselves, without identifying the perspective of rights that permeates this issue. These conflicts became revealing, to some extent, of a more active role from the subjects in relation to the existing limits.

The reactions found among the users presented themselves as important means to expand the approach of needs by the service, since in certain situations, they resulted in the disruption of established contentions. Also, workers were important agents in this expansion, through: timely needs approach, attention to unexpressed needs, intermediation of responses with other workers, sectors and community, and via relaxation of access rules to the service, especially mobilized by higher bond/accountability with users and recognition of their life reality.

This research identifies that despite the predominant conformation of the work process in the SF, which implies a selective mode to deal with health needs, users and workers also un-

dertake, with it, individual and group subjective characteristics, acting as subjects in the process, resulting in some increase in the apprehension and response to health needs. This is consistent with a caregiver assistance perspective, which is essential to deconstruct the model centered on medical practice and the production of health and autonomy, that requires the strengthening of the transformative power of individuals and potentialities present in the assistance relational encounter. In order to give value, it is important to recognize the potential and invest in concrete strategies of the subjects that extend the needs approach. The limiting strategies adopted must be recognized, situated in their social, ideological and reframed sense, mainly by the workers, and through permanent educational actions.

New studies on the relational dimension focusing on the practice in the SF should be developed, because of their importance and potential in order to broaden the understanding of intersubjectivity that permeates the approach of health needs.

REFERENCES

1. Mendes-Gonçalves RB. Práticas de saúde: processo de trabalho e necessidades. São Paulo (SP): Cefor; 1992.
2. Titoni J. Subjetividade e trabalho. Porto Alegre (RS): Ortiz; 1994.
3. Peduzzi M, Carvalho BG, Mandu ENT, Souza GC, Silva JAM. Trabalho em equipe na perspectiva da gerência de serviços de saúde: instrumentos para a construção da prática interprofissional. *Physis*. 2011 Abr-Jun; 21(2):629-46.
4. Carvalho BG, Peduzzi M, Mandu ENT, Ayres JRMC. Trabalho e intersubjetividade: reflexão teórica sobre sua dialética no campo da saúde e enfermagem. *Rev Latino-am. Enfermagem*. 2012 Jan-Fev; 20(1):19-26.
5. Fromm E. Conceito marxista do homem. 4ª ed. Rio de Janeiro (RJ): Zahar, 1967.
6. Heller A, Fehér F. A condição política pós-moderna. Rio de Janeiro (RJ): Civilização Brasileira; 1998.
7. Mandú ENT, Almeida MCP. Necessidades em saúde: questões importantes para o trabalho da enfermagem. *Rev Bras Enferm*. 1999 Jan-Mar; 52(1):54-66.
8. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. *Agir em saúde*. São Paulo (SP): Hucitec; 1997. p.71-112.
9. Stotz EN. Necessidades de saúde: mediações de um conceito [tese]. Rio de Janeiro (RJ): Fundação Oswaldo Cruz. Escola Nacional de Saúde Pública; 1991.
10. Matsumoto NF. A operacionalização do PAS de uma unidade básica de saúde do município de São Paulo, analisada sob o ponto de vista das necessidades de saúde. [dissertação]. São Paulo (SP): Universidade de São Paulo. Escola de Enfermagem; 1999.
11. Campos CMS, Mishima SM. Necessidades de saúde pela voz da sociedade civil e do Estado. *Cad Saúde Pública*. 2005 Jul-Ago; 21(4):1260-8.
12. Franco FA, Hino P, Nichiata LYI, Bertolozzi MR. A compreensão das necessidades de saúde segundo usuários de um serviço de saúde: subsídios para a enfermagem. *Esc Anna Nery*. 2012 Mar; 16(1):157-62.
13. Moraes CP. Necessidades de saúde e trabalho das equipes de saúde da família: a dialética do reconhecimento e enfrentamento [dissertação]. São Paulo (SP): Universidade de São Paulo. Escola de Enfermagem; 2008.
14. Nery AA, Mishima SM. Necessidades de saúde na estratégia de saúde da família, no município de Jequié-BA: em busca de uma tradução. *Rev Bras Med Fam Comunidade*. 2007 Jan-Mar; 2(8):314-5.
15. Egry EY, Oliveira MAC, Ciosak SI, Maeda ST, Barrientos DMS, Fonseca RMGS, et al. Instrumento de avaliação de necessidades em saúde aplicáveis na Estratégia Saúde da Família. *Rev Esc Enferm USP*. 2009 Dez; 43(Esp2):1181-6.
16. Mandú ENT, Gaíva MAM, Silva AMN. Necessidades de vida de famílias: desafios para a estratégia saúde da família. *Cienc Cuid Saúde*. 2009 Out-Dez; 8(4):548-55.
17. Silva AM. Abordagem de necessidades de saúde no encontro assistencial na Estratégia Saúde da Família em Cuiabá-MT [dissertação]. Cuiabá (MT): Universidade Federal de Mato Grosso. Programa de Pós-Graduação em Enfermagem; 2010.
18. Franco TB, Merhy EE. A produção imaginária da demanda e o processo de trabalho em saúde. In: Pinheiro R, Mattos RA, organizadores. *Construção social da demanda: direito à saúde, trabalho em equipe, participação e espaços públicos*. Rio de Janeiro (RJ): CEPESC/UERJ: ABRASCO; 2005. p.181-93.
19. Ramos DD, Lima MADS. Acesso e acolhimento aos usuários em uma unidade de saúde de Porto Alegre, Rio Grande do Sul, Brasil. *Cad Saúde Pública*. 2003 Jan-Fev; 19(1):27-34.
20. Cecílio LCO. As necessidades de saúde como conceito 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 (RJ): IMS/UERJ; 2001. p.113-126.
21. Takemoto MLS, Silva EM. Acolhimento e transformações no processo de trabalho de enfermagem em unidades básicas de saúde de Campinas, São Paulo, Brasil. *Cad Saúde Pública*. 2007 Fev; 23(2):331-40.

22. Mandú ENT, Gaíva MAM, Silva MA, Silva AMN.
Visita domiciliária sob o olhar de usuários do

Programa Saúde da Família. Texto Contexto Enferm.
2008 Jan-Mar; 17(1):131-40.

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