



Community: collective objective of nurses' work within the Family Health Strategy*

Comunidade: objeto coletivo do trabalho das enfermeiras da Estratégia Saúde da Família

Comunidad: objeto colectivo del trabajo de las enfermeras de la Estrategia Salud de la Familia

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ABSTRACT

Objective: Understanding regarding the establishment of the nurse's interaction with a community, considering the subject(s), source(s), and purpose(s), based on the perception of nurses working in Family Health. **Methods:** Exploratory descriptive study with qualitative analysis of themes developed from semi-structured interviews with 65 nurses who worked within the Family Health Strategy in southern Brazil, from January to July 2006. **Results:** Two approaches for interaction were found: an immediate one in collective entities, and secondarily, with other team members. In the end, two objects of action emerged: on the population in terms of resolution and integrality with focus on quality of action, bond formation, disease prevention and health promotion directed toward autonomy with co-responsibility; and organized team work directed at the resolution of attention. **Conclusions:** We emphasize the importance of nurse-community interaction in order to develop actions that strengthen capabilities of individuals / groups and completeness of problem solving and assistance for the organization of work.

Keywords: Public health Nursing; Family Health Program; Primary attention to health; Labor force; Work

RESUMO

Objetivo: Compreender no que concerne a constituição da interação da enfermeira com a comunidade, considerando o(s) sujeito(s) e a(s) finalidade(s) com base na percepção de enfermeiras atuantes na Saúde da Família. **Métodos:** Estudo exploratório-descritivo utilizando entrevista semiestruturada com análise qualitativa temática com 65 enfermeiras atuantes na Estratégia Saúde da Família, no extremo sul do Brasil, no período de janeiro a julho de 2006. **Resultados:** Duas abordagens da interação foram evidenciadas: imediata nas entidades coletivas; e mediata, com os demais trabalhadores da equipe. Nas finalidades, emergiram dois objetos de ação: a população na resolutividade e integralidade com enfoque na qualidade da ação, formação de vínculo, prevenção de doenças e promoção da saúde direcionada à autonomia com corresponsabilização; e a equipe na organização do trabalho direcionada à resolutividade da atenção. **Conclusões:** Enfatiza-se a importância da interação enfermeira-comunidade visando às ações que fortaleçam potencialidades dos indivíduos/grupos e integralidade e resolutividade da assistência pela organização do trabalho.

Descritores: Enfermagem em Saúde Pública; Programa Saúde da Família; Atenção primária em saúde; Força de trabalho; Trabalho

RESUMEN

Objetivo: Comprender lo concerniente a la constitución de la interacción de la enfermera con la comunidad, considerando el(los) sujeto(s) y la(s) finalidad(es) con base en la percepción de enfermeras que trabajan en la Salud de la Familia. **Métodos:** Estudio exploratorio-descriptivo en el que se utilizó la entrevista semi-estructurada con análisis cualitativo temático realizado con 65 enfermeras actuantes en la Estrategia Salud de la Familia, en el extremo sur del Brasil, en el período de enero a julio del 2006. **Resultados:** Fueron evidenciados dos abordajes de la interacción: inmediata en las entidades colectivas; y mediata, con los demás trabajadores del equipo. En las finalidades, emergieron dos objetos de acción: la población en la resolutividad e integralidad con enfoque en la calidad de la acción, formación de vínculo, prevención de enfermedades y promoción de la salud dirigida a la autonomía con corresponsabilización; y el equipo en la organización del trabajo dirigida a la resolutividad de la atención. **Conclusiones:** Se enfatiza la importancia de la interacción enfermera-comunidad con la finalidad de que las acciones fortalezcan las potencialidades de los individuos/grupos y la integralidad y resolutividad de la asistencia por la organización del trabajo.

Descriptores: Enfermería en Salud Pública; Programa Salud de la Familia; Atención primaria en salud; Fuerza de trabajo; Trabajo

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INTRODUCTION

The Family Health Team (FHS) aims, through the work of multidisciplinary teams, to develop actions directed to a delimited territory with a given population⁽¹⁾. Based on a territorial notion of work, a diagnosis of the situation is reached and actions directed to groups and behavioral, dietary and/or environmental risk factors⁽²⁾ are proposed with the agreement of the community. The goal is to provide care for individuals and families with continuous follow-up over time.

The continuity of such care facilitates and strengthens the establishment of bonds among the subjects, facilitating ties of trust, which is a factor for the success of social relationships as well as for the success and consolidation of the work performed within the FHS⁽³⁻⁴⁾.

Therefore, bonds of co-responsibility are also established to enable the development of democratic and participative managerial and healthcare practices, which in turn facilitate the identification, care delivery to and follow-up of diseases in individuals and families in the community. Further, their establishment allows focus on the promotion and maintenance of health, prevention, recovery and rehabilitation of the most frequent diseases/injuries⁽²⁾.

The work within the FHS implies the use of differentiated instruments and objects of that work that go beyond the limits of the individual subject, that is, it encompasses understanding the subject's socio-cultural environment, bonding and participation in the community as collective object/subject of action. Hence, the need to transcend the specificity of the health sector in favor of those that definitively affect the lives and health conditions of individuals, families, and communities as an interrelated whole is identified⁽⁵⁾. Consequently, frontiers of action are enlarged to promote greater an inter-sector problem-solving capacity establishing partnerships with different social and institutional entities all focused on the quality of life of individuals and their environment⁽⁶⁾.

The strengthening of health actions toward the desired outcome arises mainly from a pleasurable relationship with the object, the purpose of work and with the work itself⁽⁷⁻⁸⁾. This study emphasizes the proximity of nurses, as a labor force, to the enrolled community as an object of work, for the development of priority actions in the context of work coverage based on the characteristics identified in the community⁽⁹⁾.

It is worth noting that the community represents an element that can assume different meanings depending on the theoretical framework adopted. Hence, this study supports the central role of the meaning of community as a collective object, composed of a given set of families whom nurses work with and socio-

environmental contexts in which nurses work while within the FHS. As defined by the Family Health Policy, a community is a set of families located in a given geographical territory in a city. Another assumption is added for the effective interaction between professionals and community, which is the existence of a connector subject, a contact, a link through whom the nurse connects with the collective: a person who represents him/herself or a group in his/her community.

Hence, the connector that constitutes the subject(s) of this interaction is the contact. To understand the perception of nurses concerning their interaction with the community, one needs to grasp how they describe the essential connectors and the purpose of promoting such interactions in their daily work within the FHS.

In this context, the goal was to understand what composes the interaction of nurses with the community, considering their subject(s) and purpose(s) from the perspectives of nurses working in family health.

METHODS

This is an exploratory descriptive and cross-sectional study with a qualitative approach. It used the database of a macro project* the setting of which was the public family health care network of the 3rd Regional Coordination of Health office in the extreme south of the state of Rio Grande do Sul, Brazil. The study's population was composed of 65 nurses from the 65 teams of the Family Health Strategy existent in the semester that preceded data collection, which was performed between January and July 2006 through recorded semi-structured interviews. The interview script was previously tested with a family health team that did not belong to the group selected for the sample. The script was structured in two parts: 1) questionnaire to characterize the subjects (gender, age, background); and 2) script *per se* focused on the theme: interaction between nurses and community in the development of their work within the FHS. The interview was oriented by the following guiding questions: How is the subject of interaction between nurses and community composed? What constitutes the purpose of such interactions?

The content of the interviews was qualitatively analyzed and followed the stages of pre-analysis, exploration of the material, treatment of the obtained results and interpretations⁽¹⁰⁾ in an attempt to understand the topic from the perspective of the subjects who

* Research Program for the SUS: Participative management in health – process no 0415374. The program analyzed the current changes in the primary health care model within the organization of the Brazilian Unified Health System (SUS), which intensifies the proposal of actions comprising the transversal axes of universality, integrality and equity through the Family Health Program.

experienced it. The analysis encompasses the subject in a given socio-environmental historical time. Themes concerning what composes the interaction between nurses and the community to obtain an interpretation close to reality emerged, mainly involving the practice within the FHS.

In relation to ethical aspects, approval was obtained from the 3rd Regional Coordination of Health, RS and the Health Departments of each city involved in the study as well as from the Research Ethics Committee in the Health Field at the Federal University of Rio Grande (Process n°. 25000.092771/2004 - 88 and Protocol n° 02/2004). All the interviewees provided written consent after receiving clarification about the study's objectives and being ensured of their confidentiality. The reports' excerpts are identified with a fictitious number for city (C), the team (T) and nurse (N), e.g. C01T02N06. Therefore, the standards and guidelines regulating research with human subjects established by Resolution 196/96 of the National Health of Council were complied with.

RESULTS

Among the 65 interviewed nurses, 59 were women aged 37.6 years old on average, ranging from 24 to 55 years old. Length of work in the FHS was 25.93 months ranging from 1 to 60 months. Of these workers, 50 had a Specialization in Family Health and 15 had a Specialization in Public Health and Collective Health. In relation to postgraduate programs, four nurses had a master's degree.

Constitution of the subject(s) in the interaction between nurses and the community

Two categories emerged from the analysis of the nurses' perceptions concerning the form of contact/connection the nurses have with the community: An immediate form of connection in which interaction is directly developed between the nurse and the subject (singular or plural) that represents the collective category "community"; a mediate form of connection in which another subject exists (plural or singular) who serves as an intermediary in this interaction. The contact in its immediate form is not a representative of that collective category, but of the nurse's action, as will be shown. We emphasize that some reports have more meaning and express the empirical categories presented, meaning that the frequency with which they appear is an indicator of how frequently the content appeared in the nurses' reports.

The immediate form of connection was identified in 30 reports in which the subject of the connection is a resident in the community, the resident him/herself or

a collective representative. In the last mode, the subject appears as the representative of local collective entities such as neighborhood associations, the local health board, community radio, schools, or churches, as explained in the following reports:

There is a neighborhood association here; this is our link. Today, we scheduled a meeting with the association so that the population can express the difficulties they are having. (C08T07N39)

[...] We take the group's context and approach it, make this exchange, we're reactivating the local manager council. (C05T63N17)

[...] I'm using community radio; it has given its support. So, I disseminate information about our campaigns, activities, and radio programs. Through the association, these entities, churches. (C08T25N45)

The immediate-direct interaction between nurses and the community is based on this professional's initiative, being attentive to the needs presented in the collective dimension, which are driven by community representation, enabling a mutual and reciprocal action as evidenced by the following excerpt:

Sometimes someone in the street has problems, like an open sewer or something like that, so the community representative comes to ask for help, to see whether we can help. So, this is it, we try to make things happen, to meet the needs of people in a given moment. (C03T55N04)

[...] When there's someone who is a representative on that street, in that place [...] it is easier to first approach this person and make connections there so then I get connected with the entire community. (C05T09N09).

The reports also show in the immediate form, the contact with the community, when the nurse expresses herself from the actions performed with the different people s/he cares for, whether within the context of individual care or even in groups:

The contact with the community occurs through a group of hypertensive people, as well as prenatal and childcare groups. We make contact directly with the population, through home visits and through the day scheduled for the pre-cancer group (C05T22N24)

The mediate form of connection was found in 39 reports. As already mentioned, the contact/connector between the nurse and community in this case occurs through and/or with another FHS worker; in particular, the health community agent was predominantly identified (32 interviews) as the intermediary/support of interaction as the following excerpt reveals:

Through health community agents, who are those at one end of the process. This is the one who brings up the problems, 'speeds up' things, who knows things. We know everything about the community through this professional (C06T02N34)

Other workers were also identified in three interviews as intermediaries in the relationship with the community: nursing technicians, physicians and dentists. Four reports did not present one kind of worker in particular. In these cases, the interviewees perceived that the interaction between them and the community is in fact performed through the team—which may be associated with the perspective of teamwork in the Family Health multidisciplinary team. Nurses compose such teams. The work collective assumes the role of the subject connector for interaction, that is, the team is the one promoting interactions, whether for a single-time individual action or in a collective action.

Purpose(s) of the interaction between nurses and the community

In the work process, the action is linked to a given product, and purpose is expressed through the election of such a product, which necessarily is related to the object and/or subject of action. In other words, it is related to the element one wants to transform/modify to concretize such a purpose.

Based on this assumption, the data analysis identified to which object the nurses attached the purpose of integration with the community. Then we sought to identify meanings for “why does one promote integration?” Thus, they were asked to relate the object of action to the corresponding purpose as shown in this section. In this context, the nurses associate the purpose(s) of interacting with the assigned community to clarify two main categories related to the object contained in the purpose: the population and the staff. Then, the meanings of the purposes of interaction were grouped.

Three focuses were obtained in relation to the population: *problem-solving capacity and integrality with a focus on the quality of action* with 40 reports; *establishment of bonds* with 31 reports; *prevention of diseases and health promotion with a focus on autonomy and co-responsibility* with 14 reports.

Problem-solving capacity and integrality with a focus on the quality of action, linked to the purpose of integration between the nurse and community is highlighted in the following examples:

I think it's essential to provide good care, have a good relationship, to improve quality of life; this is our goal (C05T41N25)

[...] Problem-solving capacity is what's necessary to achieve the goal of the Health Family, which is to promote health, having

problem-solving capacity at all levels. Provide integral care. (C05T45N22)

It is to make sure that everyone who comes to the unit is well cared for and leaves satisfied. So they leave with their problem solved or, at least, on the right track, so they feel satisfied with our service and come back (C11T17N062)

Based on these reports, we emphasize that the perception of nurses in relation to solving health needs and providing integral care in their interaction with the community is directly interlinked to the quality of their work. Through this it is possible to improve individuals' quality of life.

The establishment of *bonds* as the purpose of interaction assumes the meaning of winning one's trust as reported in the following:

I guess that you are able to do good work, if they get here, look for you and trust you, they like your work, it's a signal that you are doing a good job (C05T36N19)

[...] On the team, we win this trust over time, because sometimes, there are very confidential things and sometimes, it's not exactly a health problem, but they look for you and it's really good, because we manage to captivate these people and they trust in our work as professionals (C05T38N20)

The other focus concerning the population is the purpose *prevention of diseases and health promotion with a focus on autonomy and co-responsibility*, with 14 reports represented in the following excerpts:

Health promotion. We have to show what we came for. It's a different program. Otherwise, they'll [individuals in the community] think this is only a unit they'll look for only when they want to be cured (C11T61N63)

The purpose is to make them to seek out the unit, that they practice prevention, have the information they need (C02T08N03)

Health prevention. Take care of their own health, that they value themselves more, and focus on their quality of life (C05T1N11)

From this perspective, the interaction was identified as a means to develop actions concerning health education, as work tools with which nurses are able to use the participation of the community in the construction of knowledge. The individual is thereby enabled to be a subject (agent) of promotion and maintenance of his/her own health.

In relation to promoting the autonomy of social subjects, the compromise in developing health actions enables the establishment of bonds and co-responsibility to develop work in health:

The purpose is that we are able to solve the problem. To

prepare the person so that she can, in some other opportunity, according to what is possible, to solve the problem herself (C03T19N15)

A guiding focus was identified in 20 reports in relation to the team: *work organization with a focus on problem-solving capacity*, including the meanings: fulfillment of goals, enlargement of care coverage, follow-up and evaluation of work, division of tasks and satisfaction at work. The following examples illustrate this focus:

To make a diagnosis of the community, I'd like to know exactly what the community with which I work needs and develop activities that I think would be ideal, a useful activity capable of resolving problems [...] (C05T27N10)

It is to see the return of what is being efficacious, see where the flaws are, what needs to be improved, what is more deficient in that family or person in order to devise new strategies and directly interact with them (C05T22N24)

The idea is to be able to achieve our goals within the FHS, develop our work and meet their needs, this is to provide integral care (C05T20N16)

DISCUSSION

Constitution of the subject(s) in the interaction between nurses and the community

The interaction between nurses and the community is developed in an immediate manner, working with local collective entities, which enables the transformation of social subjects into political subjects in the planning of local actions⁽¹¹⁾. These subjects are local residents and constitute, based on the instances of representations of the community collective, the collective connectors in the interaction of the ascribed community to the work of nurses.

This interaction can be developed in an immediate-direct form, in which the relation reciprocally occurs between health workers and users in the community, which shows the proximity enabled/favored by the FHS in the establishment of bonds to work with and follow-up the ascribed families⁽²⁾. It reinforces the access bond for the nurses' work, in which the community is both the object and subject of work and represents the connector for nurses and an ally in action. Hence, the attribute expected from the community is produced—what it means for the community to participate in nurses' work.

The perception of nurses concerning their work with the community, when related to their care practices, confers on the community the attribute of population, perhaps because the meaning of population is closer to the client/patient who is being cared for. Such proximity facilitates the access of the population to the nurse who,

using his/her specialized and differentiated knowledge, develops programmatic actions in the health unit and for extra-unit activities⁽¹¹⁾.

Amid the diverse possibilities of intermediations available in the community, nurses seem to be trying to develop their work supported on available resources and environments allied with the action of subjects who represent the community⁽⁴⁾. The interaction between them is possibly directed to individual and collective care in order to obtain products and outcomes that result from their way of working with and understanding the community⁽¹¹⁾. It strengthens the participation of the community working toward the social organization of health in cooperation with the object, which is seen as the subject of social knowledge⁽¹²⁾.

The interaction of the community leaders who are acknowledged individuals in the community and exert some influence on the population—including social actors, politicians, religious leaders, and educators, among others—is facilitated by the community health agent, who among his/her activities, identifies such local references and the resources available in the ascribed population, which can be enhanced by the health team and for the health team^(3,7).

In this way, the interactions between workers and community that were identified in the mediate form are related to the work performance itself, the main articulator of which is the community health agent. This professional is a member of both the health team and the community itself, hence characterized as a subject essential in the relationship and establishment of trust among those involved⁽⁸⁾. They are identified as partners who are strengthened by the health team⁽³⁾ and distinguished in the success achieved in the work developed within the FHS.

Purpose(s) of the interaction between nurses and the community

The referrals and organization of services in this field within the FHS strengthen the clarity with which the Brazilian Unified Health System views the population's improved health conditions, facilitating access to health services at different levels, thus enabling integrality of care delivery⁽¹¹⁾. Integrality in the development of teamwork has as its common goal the prevention of diseases, promotion and recovery of the community's health through changes in education, sanitation and environment, among others. Given the team's concern with the inter-sector principle⁽³⁾.

The development and maintenance of trust bonds between workers and the community began with receiving and welcoming the specific particularities of each individual, which makes it possible to work in a

more appropriate manner, ensuring a return on and credibility for the developed work. This trust should occur both ways, that is, the health team should trust its clients and the information provided and the community also needs to trust the workers when providing information concerning its habits and customs, which may be confidential. Further, the team's technical ability concerning diagnoses and prescriptions should be such that they adhere to the official recommendations and behave in such a way that inspires and reiterates such trust⁽³⁾.

The health promotion actions indicate that educational activities are characterized as strategies to face multiple health problems and their determinants, establishing an educational character whether in individual, collective or home activities, and also the use of participative methodologies⁽⁷⁾. All together, these indicate that educational practice has the potential to aid nurses in transforming the health conditions and lives of the communities with which they work.

Autonomy as a category that guides health promotion⁽¹³⁾, as well as the preservation and promotion of environments⁽¹⁴⁾ in which the community is inserted, is evident in the work. This work is differentiated in the FHS since commitment is based on the existence of bonds and co-responsibility, together favoring greater adherence in the population and the early diagnoses of diseases, which enable the delivery of integral and continuous care to the community with actions that promote health. In turn, that enables improved access to the primary health care network and the development of innovating care practices.

Teamwork is organized according to the logic of rationalization and the streamlining of tasks to meet quantitative goals⁽⁹⁾. Planning and the division of tasks, though, should have a common goal, namely, integral care with problem-solving capacity, to care for the community under the team's responsibility. The interaction established by bonds created within primary health care facilitates the identification, care and follow-up of diseases⁽⁵⁾, as well as collective interventions in the environment in which the community is inserted⁽¹⁴⁾.

This dynamic interconnection of nursing work with the community promotes the follow-up and evaluation of care delivery according to manifestations identified in the community itself, because it involves the collective responsibility of its members in the results obtained from such work⁽¹⁵⁾. The goal within the FHS is to provide integral and continuous high quality care with

problem-solving capacity in order to meet the health needs of the community⁽¹⁾. Nurses feel valued when the community acknowledges good outcomes, which in turn strengthens the nurses' autonomy in their field of work⁽¹¹⁾.

The conclusion is that even though the developed work is directed to different objects, the focus remains on work—for the community, for the work force and/or for the work itself—directed to attaining the final product, which is the health of the community.

FINAL CONSIDERATIONS

Based on the analysis proposed in this study, to address the interaction of nurses with the communities assigned to their responsibility within the FHS, we determined that the constitution of the subject(s) includes individuals who represent groups or collective entities, or even represent themselves, in such interactions. Hence, two forms of contact/connection, the immediate and mediate, were identified. This identification is important because it reveals how the nurses view the collective object of their work, the community, and based on that, how they interact with it.

From this perspective, the participation of nurses working in different spaces, considering the local characteristics and respective contacts, is apparent. Since diverse subjects in the community enable this work, it can be supported on ties of trust and strengthen collective potential of those involved in the relationship of interactions.

The purposes of these nurse-community interactions are directed to solve the population's problems with a focus on quality of care, establishment of bonds, health promotion and the prevention of diseases, as well as promoting autonomy and co-responsibility in developing the integrality of actions. In relation to the team, purposes include work organization and increasing problem-solving capacity with a focus on the worker and team. The relevance of nurses' interactions to the integrality and problem-solving capacity of actions, teamwork efficiency and organization, and professional satisfaction is emphasized.

The conclusion is that the close interaction between nurses and the community for whom they are responsible enables a more precise identification of local priorities and the scope context of care and the development of health actions appropriate to improve individuals' quality of life.

REFERENCES

1. Andrade LOM, Barreto ICHC, Bezerra RC. Atenção Primária à Saúde e a Estratégia Saúde da Família. In: Campos GWS, organizador. Tratado de saúde coletiva. São Paulo: Hucitec, Rio de Janeiro: Fiocruz; 2006.
2. Brasil. Ministério da Saúde. Portaria n° 648, de 28 de Março de 2006. Aprova a Política Nacional de Atenção Básica,

- estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). Diário Oficial da União. República Federativa do Brasil. Ministério da Saúde, Gabinete do Ministro. Edição nº 61 de 29/03/2006.
3. Valentim IVL, Krueh AJ. A importância da confiança interpessoal para a consolidação do Programa de Saúde da Família. *Ciênc Saúde Coletiva*. 2007;12(3):777-88.
 4. Marin MJS, Oliveira LR, Ilias M, Higa EFR. Community contributions to a FHU team work. *Rev Latinoam Enferm*. 2007;15(6):1065-71.
 5. Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. Coordenação de Saúde da Comunidade. Saúde da Família: uma estratégia para a reorganização do modelo assistencial. Brasília: Ministério da Saúde; 1997.
 6. Cezar-Vaz MR, Muccillo-Baisch AL, Soares JFS, Weis AH, Costa VZ, Soares MCF. Nursing, environment and health conceptions: an ecosystemic approach of the collective health production in the primary care. *Rev Latinoam Enferm*. 2007;15(3):418-25.
 7. Heringer A, Ferreira VA, Acioli S, Barros ALS. Práticas educativas desenvolvidas por enfermeiros do Programa Saúde da Família no Rio de Janeiro. *Rev Gaúch Enferm*. 2007;28(4):542-8.
 8. Seoane AF, Fortes PAC. A percepção do usuário do Programa Saúde da Família sobre a privacidade e a confidencialidade de suas informações. *Saúde Soc*. 2009;18(1):42-9.
 9. Santos VC, Soares CB, Campos CMS. A relação trabalho-saúde de enfermeiros do PSF no município de São Paulo. *Rev Esc Enferm USP*. 2007;41(N Spe):777-81.
 10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8a. ed. São Paulo: Hucitec; 2004.
 11. Nascimento MS, Nascimento MAA. Prática da enfermeira no Programa de Saúde da Família: a interface da vigilância da saúde versus as ações programáticas em saúde. *Ciênc Saúde Coletiva*. 2005;10(2):333-45.
 12. Cezar-Vaz MR. A enfermagem em saúde coletiva: poder e autonomia na organização tecnológica do trabalho interdisciplinar da rede básica de serviços públicos de saúde num espaço ecossistêmico [relatório de pesquisa - CNPq – Processo 470627-2001-8 – Edital Universal]; 2003.
 13. Fleury-Teixeira P, Vaz FAC, Campos FCC, Álvares J, Aguiar RAT, Oliveira VA. Autonomia como categoria central no conceito de promoção de saúde. *Ciênc Saúde Coletiva*. 2008;13(Supl 2):2115-22.
 14. Cezar-Vaz MR, Weis AH, Costa VZ, Soares JFS, Bonow CA, Cardoso LS, et al. Estudo com enfermeiros e médicos da atenção básica à saúde: uma abordagem socioambiental. *Texto & Contexto Enferm*. 2007;16(4):645-53.
 15. Colomé ICS, Lima MADS. Desafios do trabalho em equipe para enfermeiras que atuam no Programa Saúde da Família (PSF). *Rev Gaúch Enferm*. 2006;27(4):548-56.