Perceptions of Primary Health Care needs according to users of a health center

PERCEPÇÕES SOBRE NECESSIDADES DE SAÚDE NA ATENÇÃO BÁSICA SEGUNDO USUÁRIOS DE UM SERVIÇO DE SAÚDE

PERCEPCIONES SOBRE NECESIDADES DE SALUD EN LA ATENCIÓN BÁSICA, SEGÚN USUARIOS DE UN SERVICIO DE SALUD

Paulo Alexandre de Moraes[1], Maria Rita Bertolozzi[2], Paula Hino[3]

ABSTRACT

This qualitative, exploratory study was performed with the purpose of identifying the concept of health needs according to the perception of health service users located in the State of São Paulo. Fifteen interviews were performed using a semi-structured script, in January 2009. The exhaustive reading of the interviews allow for identifying the elements that comprise the categories, which had been previously defined according to the Taxonomy of Health Needs. It was observed that users view themselves as holders of needs: the social context may strongly affect their health, and therefore the users have the need for autonomy in making decisions. As for attachment, it is observed that it is closely related to the autonomy/self care needs, as, in a certain way, it is necessary to strengthen the trust relationship so that the potentials to face the health-disease process may also be strengthened. In conclusion, there is a need for instruments that help collective health professionals to identify the health need of users.

KEY WORDS
User embracement.
Primary Health Care.
Health services needs and demand.
Health personnel.

RESUMO

Trata-se de pesquisa qualitativa de caráter exploratório, com o objetivo de conhecer o conceito de necessidades de saúde, segundo a percepção de usuários de um serviço de saúde do interior paulista. Realizou-se 15 entrevistas, por meio de roteiro semi-estruturado, em janeiro de 2009. A leitura exaustiva das entrevistas permitiu a apreensão de elementos constitutivos das categorias, definidas a priori, segundo a Taxonomia das Necessidades de Saúde. Identificou-se que os usuários perceberam-se como detentores de necessidades; o contexto social pode apresentar forte influência na sua saúde, verificando-se que a autonomia na tomada de decisões é uma necessidade. Quanto ao vínculo, percebe-se que está intimamente ligado às necessidades de autonomia/autocuidado, pois de certo modo é reforçando a relação de confiança que será possível fortalecer os potenciais para o enfrentamento do processo saúde-doença. Conclui-se que existe a necessidade de instrumentos que auxiliem o profissional da área da Saúde Coletiva a identificar as necessidades de saúde dos usuários.

DESCRITORES
Acolhimento.
Atenção Primária à Saúde.
Necessidades e demandas de serviços de saúde.
Pessoal de saúde.

RESUMEN

Se trata de una investigación cualitativa de carácter exploratorio, con el objetivo de conocer el concepto de necesidades de salud, según la percepción de usuarios de un servicio de salud del interior paulista. Fueron realizadas 15 entrevistas, a través de guión semiestructurado, en el mes de enero de 2009. La lectura exhaustiva de las entrevistas permitió el aprendizaje de elementos constitutivos de las categorías, que fueron definidas a priori según la Taxonomía de las Necesidades de Salud. Se identificó que los usuarios se percibieron como detentores de necesidades, el contexto social puede presentar fuerte influencia en su salud, verificándose que la autonomía en la toma de decisiones es una necesidad. En cuanto al vínculo, se percibe que está íntimamente ligado a las necesidades de autonomía/autocuidado, pues de cierto modo, reforzándose la relación de confianza, será posible fortalecer los potenciales para el enfrentamiento del proceso salud-enfermedad. Se concluye respecto de la necesidad de instrumentos que auxilien al profesional que actúa en el área de Salud Colectiva a identificar las necesidades de salud de los usuarios.

DESCRIPTORES
Acogimiento.
Atención Primaria de Salud.
Necesidades y demandas de servicios de salud.
Personal de salud.

[1] Student in the Specialization Course in Collective Health, University of São Paulo School of Nursing. Nurse, Centro de Saúde São José, Campinas. Campinas, SP, Brazil. moraes_enf@yahoo.com.br   [2] Associate Professor, Collective Health Nursing Department, University of São Paulo School of Nursing. São Paulo, SP, Brazil. mrbertol@usp.br   [3] RN. Post-Doctoral fellow, Collective Health Nursing Department, University of São Paulo School of Nursing. São Paulo, SP. Post-Doc Grantee - CNPq. São Paulo, SP, Brazil. paulahino@yahoo.com.br

INTRODUCTION

Health needs are neither restricted to biological demands, nor can they be considered individual and isolated[1]. From a Collective Health perspective, these needs should be articulated with social needs, which are heterogeneous and originate in the reproduction of life in society[2]. Although health needs are socially determined and constructed, they can be apprehended in their individual dimension, expressing a dialectical relation between the individual and society[3].

Health care should be planned in view of these needs and health services should be prepared to deal with them, understanding the meanings of their nature at the interface with the subjects implied - at the moment health is produced and consumed - so as to try and enhance the subjects' autonomy.

To get to know the health needs, identifying the form and repercussions of the subjects' insertion at the moment health is produced, social production requires apprehending the objective reality, at the same time as the subjective conceptions emerging from individuals, identifying the different meanings attributed to their ways of life, health and suffering, which can reveal the transformative potential of current health practices[4].

Adopting user-centered practices demands that health services incorporate light technologies, materialized in relational practices like welcoming and bonding[5-6]. Listening to users' needs allows health professional to expand the care capacity and enhance interventions directed at the problems the population brings, which translates into greater problem-solving ability of care delivery[7].

The power to satisfy needs lies in the product of a work process. A consubstantial and circular relation exists between the need and the work process established to satisfy it. In this perspective, needs are neither natural nor homogeneous. The distribution and consumption of the products of the work process are unequal too[8].

Knowledge about users' health needs can improve care and, therefore, it is fundamental for workers to show themselves open to qualified listening[9].

As the apprehension and understanding of conceptions regarding health needs contribute to the transformation of health practices, this study is justified because it stimulates debate on this issue, with a view to improving health care. The goal was to get to know the health needs concepts as perceived by users of a health service in the interior of São Paulo State.

METHOD

An exploratory and qualitative study was carried out, based on user testimonies at a health service. Qualitative studies permit the apprehension and analysis of reality which, given its dynamics and complexity, should not remain limited to the quantification of events[10]. Exploratory research permits surveying information on a given objects, in a delimited work area, and to map the conditions of its manifestation[11].

The study scenario was a health unit in an interior city located in the Southeast of São Paulo State. It is a large unit and a hybrid service as it joins some specialties in a traditional primary health care unit and, since 2001, has incorporated four family health teams. When data were collected, i.e. in the first two weeks of 2009, the health unit's coverages area included an estimated population of 53,334 inhabitants.

Eighteen health service users were invited, aged 18 years or older and in health conditions that would not interfere in the quality of interview answers. These subjects were contacted while awaiting a previously scheduled appointment. The number of participants was determined by saturation in the collected information, that is, based on the repetition of ideas contained in the statements.

The interviews were held in the afternoon period at a private room to avoid possible interferences, with a mean duration of ten minutes. They were based on a semistructured script with two parts: Part A contained socio-demographic variables and Part B comprised guiding questions on the study theme: *What is a health need*? and *Do you believe that your needs are satisfied at this service?*. These guiding questions were adopted to allow the interviewee to freely discuss the theme. The interviews were tape-recorded and fully transcribed by the researcher responsible for their accomplishment.

Health needs were analyzed in the light of the Health Needs Taxonomy, proposed by Norma Fumie Matsumoto and Luis Carlos de Oliveira Cecílio. These authors propose classifying the concept in four groups: good living conditions; access to any health technology that can improve and extend life; creation of affective bonds and growing levels of autonomy. This Taxonomy *[...] questions elements to understand reality based on the perspective of the subjects immersed in society and, as such, potentially loaded with needs in leading their lives*[7,12]. Exhaustive reading of the interviews permitted apprehending constitutive elements of the proposed classification, that is, immersion in the testimonies made it possible to identify the elements that showed correspondence with the adopted Taxonomy.

The subjects were invited to participate voluntarily, in accordance with the Informed Consent Term used. Initially, the project was submitted to the Institutional Review Board of the University of São Paulo School of Nursing and received approval under Opinion No 783/2008.

> Knowledge about users' health needs can improve care and, therefore, it is fundamental for workers to show themselves open to qualified listening.

20 Rev Esc Enferm USP
2011; 45(1):19-24
www.ee.usp.br/reeusp/

Perceptions of Primary Health Care needs
according to users of a health center
Moraes PA, Bertolozzi MR, Hino P

RESULTS

Subject characteristics

Eighteen health service users were invited to participate, three of whom refused to be part of the research. The interviewees were women and mostly (13 subjects) between 20 and 39 years old. Seven subjects came from São Paulo City and eight from other cities in São Paulo State.

When asked about how long they were living in the neighborhood and how they qualified the place, 12 subjects considered it good, two bad and one very good. Time living in the neighborhood ranged from less than one year to 33 years, with three interviewees living there for less than one year, eight between one and 15 years, three between 20 and 25 years and one for 33 years.

As for insertion in work, eight out of 15 study participants indicated no formal job and alleged self-employment. When asked about monthly income, 12 people answered gaining between one and six minimum wages, without specifying whether this referred to individual or family income, and three refused to provide this information.

Health needs

When questioned whether the health service attended to their needs, ten subjects gave affirmative answers. As mentioned, the testimonies were analyzed according to the Taxonomy of Health Needs[7,12]. Critical reading of the testimonies permitted their grouping according to the following classification.

Need for good living conditions

The needs for good living conditions include the right to housing, to basic sanitation, to adequate food, to employment, education, among others[12]. Moreover, as one of the proponents of the Taxonomy defends, *[...] the way one lives 'translates' into different health needs*[7].

Next, excerpts of the testimonies demonstrate that people relate the needs with their way of life:

[...] you need to have a good job, [...] good education, to make a good salary and, through a good salary, you can get several other things, including our health area too (LMA, 34 years).

[...] basic sanitation, access to health, having a specialized health service in your neighborhood, [...] transportation [...], that is part of it, [...] living well with you family in harmony [...] (CPAS, 32 years).

Need for access to any health technology that can improve and extend life

This refers to the use of *the right technology, at the right time*[12]. What is more, *[...] the usage value of each health technology is always defined based on each person's need, at each singular moment (s)he experiences*[7].

In the interviews, the users' desire was evidenced to get immediate and qualified access to health care Technologies, as shown next.

[...] what the user needs, medical care, medication, [...] specialty, mainly [...] (MPSA, 39 years).

[...] it was a high-risk pregnancy, I needed a consult with a psychologist, psychiatrist, I got depressed, because I almost lost the baby, each time I needed to I came here and the professional I needed were available [...] (MBA, 22 years).

As opposed to the above fragments, others demonstrate dissatisfaction with access to the health service:

[...] EMS, [...] depending on EMS you'll never get there, [...] it should be improved [...] (SPS, 43 years).

[...] if you arrive and need a specialist, you can't get one, because you're not forwarded by a general clinician [...] (MYT, 30 years).

Need for (a)effective bonding between user and a professional or a health team (subjects in relation)

According to one of the authors who propose the Taxonomy adopted in this study, the user's bond with the health professional or team makes it possible to transform daily practice and values the construction of autonomous subjects. Therefore, it is necessary to: *[...] re-establish the art of talking and listening between professionals and users, between team and family, between institution and society*"[12]. Hence, the relation between users and health professional should be as good as possible and empathy should be mutual. Bonding means the establishment of a continuous, personal, warm and untransferable relation. As the author defends, it permits the encounter of subjectivities[7].

The fragments below reveal the importance users attach to bonding, besides the fact that the physician is the most mentioned professional in the relation with the health service:

[...] sometimes, you know a doctor, the doctor already knows your need and you can't get a consult with that doctor, because that doctor works with another team, [...] there's a doctor you sympathize with more [...] (LMA, 34 years).

[...] it is important to have a good relation with your doctor [...] (CR, 21 years).

On the other hand, some users appointed difficulties in the relation with the medical professional and compared the professional's attitude between the public and private service:

[...] you have to get Dr. X out of here, I don't like him, [...] he doesn't even look at us [...] (CPAS, 32 years).

[...] it is well attended by the doctor (from the health insurance) and, if the same doctor who attends in the consultation room attends through the SUS, it's another type of attendance, [...] totally different (CR, 21 years).

Perceptions of Primary Health Care needs
according to users of a health center
Moraes PA, Bertolozzi MR, Hino P

Rev Esc Enferm USP
2011; 45(1):19-24
www.ee.usp.br/reeusp/

21

Need for autonomy and self-care in the choice of the way to lead life *(construction of the subject)*

According to one of the authors who proposed the Taxonomy, the goal of therapeutic work should be to raise the users' ability for autonomy, conceiving the individual as a subject able to choose their *way to lead their lives*[12]. Autonomy implies

[...] the possibility for the subjects to reconstruct the meanings of their life and this resignification would actually influence their way of life, including the fight to have their needs attended to in the broadest possible way[7].

In the testimonies, this category was evidenced as shown below.

[...] good clarification too, sometimes he [the user] wants to solve doubts and finds someone [health professional] to solve this doubt too (MPSA, 39 years).

[...] I think health starts at home too, [...] starting at the moment when you take care of yourself [...] (MAPM, 27 years).

After reading and analyzing the testimonies, a new category emerged which the Taxonomy of Health Needs did not cover. Given its relevance, it was incorporated in the following presentation and is related with the production process of health services, so that it was denominated: Need related to the health service production process, covering questions more related to health service organization, which permit service access:

[...] The issue is not restricted to how many entry doors there are but, mainly, quality is questioned. Hence, it is the way the person experiences the health services. Thus, the importance of qualifying access is highlighting, including aspects of the work process organization and dynamics, considering the contribution and importance of analyzing various aspects[9].

[...] today, my daughter is coming for a consult [...] and the person only let us know very at the last minute that her appointment would not be at the scheduled time [...] (LMA, 34 years).

[...] I had to see a psychologist, first I had to see the clinician [...] I don't like that [...] what does the general clinician have to do with the psychologist? [...] (DKB, 22 years).

DISCUSSION

The analysis of the testimonies reveals that most of the needs are connected with the production and social reproduction and accessibility of health actions. Bonding, on the other hand, seems to be intimately related with the needs for autonomy and self-care. In fact, the relation of trust permits strengthening potentials to cope with the health-disease process.

In a study involving users from families followed by a family health team in Jequié-BA, the subjects conceive the health-disease as a fruit of social production and reproduction, evidenced by the health conditions; they reported that

the purchasing power interfered in their living conditions, including access to education, leisure, employment and other situations, such as sewage network, paved streets, among other aspects[13].

In this study, when appointing daily facts, mainly related with the family, food, housing, study and work, it is evidenced that users perceive that these needs affect health. They acknowledged that financial support entails consequences corresponding to physiological alterations, when they feel concerned with family support and end up getting ill.

In general, it is important to highlight that, at health services, users seek answers for clinical complaints. No immediate connection is revealed, however, between their health needs and the peculiarity of their insertion in society. That is so because, traditionally, people understand the biological dimension of the health-disease process in a more concrete way and do not associate it with the social issues that strengthen or exhaust the life process.

It was also evidenced that health center centers on the physician and that it is difficult to detach health from this worker's character, evidencing the hegemony of the biomedical model, as observed in a study carried out in Jequié-BA, in which *[...] the research subjects reported that the physician served as their reference as a health caregiver*[13].

In this study, the testimonies evidence that the health-disease process manifests itself in different social groups, covering society's structural processes and their social reproduction profiles, with their corresponding strengths and weaknesses and the understanding of the biological phenomena that *[...] compose these groups and their individuals' typical health-illness patterns"*[1]. Reinforcing the theme, although the health-disease process is collective, its manifestations occur in individual bodies, as well as in the apprehension of health needs[14].

The users highlight another important aspect, which relates to the health system's provision of technologies, categorized as *Need for access to any health technology that can improve and extend life*. Health production, based on the worker/user intersection, requires articulation among care technologies that produce singular care, bonding and accountability[5]. Thus, health services should be prepared to deal with health needs, understand and produce meanings on their nature, at the interface with the subjects implied at the moments of health production and consumption, in the attempt to promote subjects' autonomy.

In general, users go to health services seeking technologies that can make them get better, even though they basically are not necessary in some cases. This was evidenced, for example, when they appointed access to x-rays and ultrasound medical imaging. The ways in which health practices have established themselves in current society, with a prevalence of costly technologies that are not always fundamental for diagnosis and treatment, modulate people's behavior regarding the use of these resources.

22
Rev Esc Enferm USP
2011; 45(1):19-24
www.ee.usp.br/reeusp/

Perceptions of Primary Health Care needs
according to users of a health center
Moraes PA, Bertolozzi MR, Hino P

As observed, some study subjects seem to be satisfied with the actions the health unit offers, when they mention positive points, like access to medical imaging and regarding the bond that is established.

As for bonding, as mentioned, the potential satisfaction of needs lies in the product of a work process, revealing a consubstantial and circular relation between the need and the work process established to fulfill it[8]. During care, empathy needs to exist between user and health professional, and this can guarantee adherence to the therapeutic project and to treatment success.

The value users attribute when health professionals pay attention during care delivery was evidenced, ranging from reception to the moment of the consultation, including all other instances users attend at the service. These attitudes seem simple, such as explaining the motives for non-immediate attendance, besides other attitudes health professionals often do not value in the same way, allow users to perceive their importance at the health service. This also contributes to treatment success. That is why some users claim greater attention by all service members, particularly the need for clarifications on health-related topics.

At certain times, they reported that, despite access to health actions, they were dissatisfied, as the service did not manage to respond to their expectations, like for example: immediate access to professionals working at the unit and access to specialists, as well as to high-complexity tests.

In this respect, in an above-mentioned study, carried out in Jequié-BA, the subjects complained that professionals did not have time to listen to them due to the great care demand, which made it impossible for them to talk about their health, and that they were not familiar with the physician either to talk about their personal problems[13].

About autonomy, in certain interviews, it was evident that users present these care and health maintenance needs. It was also verified that, when users turn to the service for care, they also attempt to solve doubts and/or seek answers on how to proceed in self-care.

It should be taken into account that the needs for health information and education are only parts of the construction process of people's autonomy, as autonomy implies the possibility for subjects to reconstruct the meanings of life and this resignification actually influences their way of life, articulated with the fight to get their needs satisfied in the broadest possible way[7].

Autonomy is intimately associated with the *Need for (a)effective bonding between users and professionals or a health team (subjects in relation)*, as bonding promotes the possibility for health professionals to propose more appropriate therapeutic projects for the sick subjects' life reality. This, in turn, can determine greater chances of their adherence to treatment, which contributes to promote autonomy and decision-making power on their health-disease.

Bonding should be considered more than the adscrip-tion to a service or formal registration in a program, as it means the establishment of a continuous relation over time, personal, untransferable and promoting the encounter of subjectivities[7].

With regard to the *Needs related to the service production process* category, most user mentions are related with non-satisfaction of certain needs, such as the way they are attended at the reception desk, the lack of communication and difficulty to accept that they need to be assessed by the clinicians to be forwarded to another specialty.

A study carried out in three capitals in the Brazilian Northeast on the assessment of access and welcoming, based on the perceptions of primary health care users and professionals' perceptions, appointed that the impersonal way in which professionals dealt with users was qualified with discontentment, due to the way some professionals (un)welcome users, highlighting *knowing how to treat people well* as a fundamental aspect of professional education, particularly for people working at the reception desk. They also underlined satisfaction with some professionals' welcoming, considering an act of education and respect[9].

Although users in this study reported that they felt the health service supported them, when they needed access to care technologies, to health professionals and medication, they complained about the difficulty faced to access some health services, such as tests and consultations outside the health unit, mainly involving specialists.

Hence, the ways to organize the health system need to be reconsidered, as the apparent *rational* organization of the service may not correspond with the health needs the users present. It should be taken into account that access to the health system and its technologies does not occur equitably, although this is determined in the constitution of the Unified Health System (SUS).

A study that looked at the health needs of people living in the coverage area of a Basic Health Unit in São Paulo City indicated that the work process should be established based on the acknowledgement of users' health needs, who recognized the presence of the State, social reproduction and political participation as health needs[8].

The health service needs to diversify the *service portfolio*, in order to attend to the *health needs portfolio*[7] the user brings along. Therefore, health professionals should *auscultate* the individuals, perceiving them in a broad sense, in all of their dimensions: biological, emotional and related with their social insertion, which evidence distinct strengths and weaknesses to face the health-disease process.

It should be taken into account that it will be difficult to achieve total comprehensiveness at any health services, no matter the availability of trained health professionals and no matter how good work conditions are. Hence, comprehensiveness is considered as a process that depends on the professionals' degree of commitment and ability to enhance listening, in the attempt to understand, in a multidisciplinary way, if necessary, the demands users present[7]. Moreover, comprehensiveness involves articulation with

Perceptions of Primary Health Care needs
according to users of a health center
Moraes PA, Bertolozzi MR, Hino P

Rev Esc Enferm USP
2011; 45(1):19-24
www.ee.usp.br/reeusp/

23

other health services and sectors that are direct or indirectly related with health.

Based on the above, it is fundamental for health workers to acknowledge health needs in the broadest possible way, so that the concept is not reduced to the clinical and biological spheres, but incorporates the dimension of individuals' insertion in society, besides the way the health services is organized to see to and recognize health demands.

CONCLUSION

Through this study, it could be verified that, although the concept of health needs is not explicit for health service users, they are present. Users seem to understand the association between their social situation and the health-disease process and, even if in a not totally evident way, relate their vulnerability with social insertion. In their testimonies, all component dimensions of the Health Needs Taxonomy were found, which was used in this study. These are related with the living conditions, access to goods and services, the bond with health professionals, the achievement of autonomy in decision making on how to lead one's life and the organization and quality of the health actions they have access to.

This study permitted identifying tensions involving the conflict expressed between what users present as health demands and their acknowledgement as needs by health professionals. The relevance of adopting a rationale, a logic is highlighted, guiding health professionals' apprehension and decoding of needs. This is possible through the adopted Taxonomy, as it provides instruments to understand health needs, affecting their satisfaction in practice.

This study showed the urgent need to equip Collective Health professionals to understand what users want, by apprehending these concepts and seeking routes towards humanized and qualified care. Therefore, the fundamental importance of continuing education is highlighted, so that health professionals incorporate these concepts in their daily work, and also include aspects that can contribute to the reorganization of health services' work and functioning process, based on the population's health needs. It is important to awaken professionals to this theme since undergraduate education, learning how to deal with these concepts in the care process.

This study did not intend to offer a response to solve service demands, but to discuss the concepts that help to understand the health needs the users bring.

REFERENCES

1. Breilh J. Epidemiologia e economia, política e saúde. São Paulo: Hucitec; 1991.

2. Barros DG, Chiesa AM. Autonomia e necessidade de saúde na Sistematização da Assistência de Enfermagem no olhar da saúde coletiva. Rev Esc Enferm USP. 2007;41(n.esp):793-8.

3. Stotz EM. Trabalhadores, direito à saúde e ordem social no Brasil. São Paulo Perspect. 2003;17(1):25-33.

4. Nakamura EE, Egry EY, Campos CMS, Nichiata LYI, Chiesa AM, Takahashi RF. O potencial de um instrumento para o reconhecimento de vulnerabilidades sociais e necessidades de saúde: saberes e práticas em saúde coletiva. Rev Lat Am Enferm. 2009;17(2):253-8.

5. Merhy EE. Em busca do tempo perdido: a micropolítica do Trabalho Vivo em saúde. In: Merhy EE, Onocko R, editoras. Agir em saúde: um desafio para o público. São Paulo: Hucitec; 1997. p.71-112.

6. Merhy EE. A perda da dimensão cuidadora na produção de saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Campos CR, organizador. Sistema Único de Saúde em Belo Horizonte: reescrevendo o público. São Paulo: Xamã; 1998. p.103-20

7. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e eqüidade na atenção em saúde. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: IMS/UERJ; 2001. p. 113-26.

8. Campos CMS, Mishima SM. Necessidades de saúde pela voz da sociedade civil (os moradores) e do Estado (os trabalhadores de saúde). Cad Saúde Pública. 2005;21(4):1260-8.

9. Souza ECF, Vilar RLA, Rocha NSPD, Uchoa AC, Rocha PM. Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais de saúde. Cad Saúde Pública. 2008;24 Supl 1: S100-10.

10. Minayo MCS, Gomes FD. Pesquisa social, teoria, método e criatividade. Petrópolis: Vozes; 2007.

11. Severino AJ. Metodologia do trabalho científico. São Paulo: Cortez; 2007.

12. 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: Escola de Enfermagem, Universidade de São Paulo; 1999.

13. Nery AA. Necessidades de saúde na estratégia de Saúde da Família, no município de Jequié-BA: em busca de uma tradução [tese doutorado]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2006.

14. Laurell AC. A saúde como processo social. In: Nunes ED, editor. Medicina social: aspectos históricos e teóricos. São Paulo: Global; 1993. p. 133-58.

Correspondence addressed to: Paulo Alexandre de Moraes
Rua Fritz Gut, 300 - Vila São Jorge
CEP 11085-730 - Santos, SP, Brazil