
LONGITUDINALITY OF CARE IN NURSES' PRACTICE: IDENTIFYING THE DIFFICULTIES AND PERSPECTIVES OF CHANGE¹

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ABSTRACT: The objective of the present study was to identify, from the perspective of nurses associated with Family Health Strategy of the 10th Regional Health District, how the longitudinality of care takes place in their practice, with emphasis on the difficulties and possibilities of its development. This descriptive-exploratory, qualitative study was performed with twenty Family Health Strategy nurses from cities covered by the 10th Regional Health District of Paraná, Brazil, through semi-structured interviews and using content analysis. It was evidenced there is a need to make the Family Health Strategy proposals effective, improve teamwork, the professional profile, the health worker-client attachment, accessibility and feedback system, and also change the curative view of the population and invest in health units. In conclusion, in order to implement longitudinal care it is necessary to make adequacies in the implementation of the Family Health Strategy, so that health workers and clients act according to their own principles.

DESCRIPTORS: Family health. Continuity of patient care. Nurse's role.

LONGITUDINALIDADE NO TRABALHO DO ENFERMEIRO: IDENTIFICANDO DIFICULDADES E PERSPECTIVAS DE TRANSFORMAÇÃO

RESUMO: Com o presente estudo objetivou-se conhecer, na perspectiva dos enfermeiros atuantes na Estratégia Saúde da Família no âmbito da 10^a Regional de Saúde, como se dá a longitudinalidade do cuidado em seu trabalho, com ênfase nas dificuldades e possibilidades quanto ao seu desenvolvimento. Trata-se de um estudo descritivo-exploratório e qualitativo realizado com vinte enfermeiros da Estratégia Saúde da Família de municípios da 10^a Regional de Saúde do Paraná, mediante entrevistas semiestruturadas cujos dados foram submetidos à análise de conteúdo. Evidenciou-se a necessidade de melhorias nos aspectos efetivação das propostas da Estratégia Saúde da Família, atuação em equipe, perfil profissional, mudança na visão curativista da população, investimentos nas unidades de saúde, vínculos entre profissional e usuários, acessibilidade e sistema de contrarreferência. Concluiu-se que para a efetivação do cuidado longitudinal são necessárias adequações na implementação da Estratégia Saúde da Família, de modo que profissionais e usuários atuem conforme seus princípios.

DESCRIPTORES: Saúde da Família. continuidade da assistência ao paciente. Papel do profissional de enfermagem.

LONGITUDINALIDAD EN EL TRABAJO DEL ENFERMERO: IDENTIFICANDO DIFICULTADES Y PERSPECTIVAS DE TRANSFORMACIÓN

RESUMEN: Estudio cuyo objetivo fue conocer bajo la perspectiva de los enfermeros-actores en la Estrategia de Salud de Familia, en el ámbito de la 10^a Región de Salud, como se da la longitudinalidad del cuidado en su trabajo. Investigación cualitativa descriptiva-exploratoria, realizado en abril de 2010, con 20 enfermeros de Paraná, se utilizaron entrevistas semiestructuradas y los datos fueron sometidos al análisis de contenido. Se evidenció la necesidad de mejorías: en la efectuaación de propuestas de la Estrategia Salud de la Familia, actuación en equipo, perfil profesional, cambio en la visión curativa de la población, inversiones en las unidades de salud, mejoría de vínculos entre profesional/usuarios, accesibilidad y sistema de contra-referencia. Se concluye que para efectividad del cuidado longitudinal son necesarias adecuaciones en la implementación de la Estrategia Salud de la Familia, de modo que profesionales y usuarios actúen conforme sus principios.

DESCRIPTORES: Salud familiar. Continuidad de la atención al paciente. Rol de la enfermera.

INTRODUCTION

Family Health Strategy (FHS), the main current care model structuring Primary Health Care (PHC) in Brazil was created by the Department of Health (DH) in 1994 with the aim to reorganize the traditional model of providing health care focusing on the family.¹

In this model, in order for healthcare to be provided, it is essential to execute a multi-professional work composed at least by doctors, nurses, nurses' aides/nursing technicians and community health agents (CHAs).² The FHS must act with a view to ensure care delivery follow-up by a continuous sector flow, not disregarding healthcare comprehensiveness and the creation of commitment and responsibility ties that are shared between healthcare providers and the population.³

PHC is guided by four basic principles – the first contact, longitudinality, comprehensiveness and care delivery coordination⁴ – and it has the FHS as its main care model. In addition, these attributes are essential for developing the work within FHS, since they guide this care model, resulting in a need to understand them, apply and evaluate them in order to make their proposal effective.

Longitudinality, which is considered a central feature of PHC, is understood as the regular care delivery by the health team and its consistent use throughout the years. The main mean to perform longitudinal care is for the team to learn about clients within their context, with their social, economic and cultural characteristics.⁴

Longitudinality is developed in the moment the health care team becomes a continuous care provider, regardless of the existence or not of specific issues related to health or the type of illness. It is established when the client searches the Family Healthcare Unit (FHU) and establishes a long-term relation.⁴

Nurses, one of the FHS team members, has the essential attributes to provide longitudinal care, since nurses' actions are aimed, namely, at providing comprehensive care to individuals and families in the FHU and, whenever recommended, at their homes and/or other community spaces to all human development stages: childhood, adolescence, adult age and the elderly.⁵

Longitudinality is essential for nurses' action in the FHS. It improves care delivery since

it enables professionals to elaborate a more precise and efficient action plan. Moreover, literature has made a poor approach to the theme of longitudinal care, a fact that demonstrates the need for more studies on the subject. It is also important that nurses can perceive their work under a long-lasting perspective so that longitudinality can occur and be improved for FHS reality.

In this sense, this present study had the objective to identify, from the perspective of nurses associated with the FHS, covered by the 10th Regional of Health District of Paraná, how longitudinality of care occurs within their practice, emphasizing on the difficulties and possibilities for its development.

METHODOLOGY

This descriptive-exploratory qualitative study is part of the research proposal "Care delivery and educational work in the everyday lives of FHP nurses – characteristics and challenges", funded by The Araucária Foundation.

The study was performed within the 10th Regional Health District (RHD) of Paraná, with headquarters in the city of Cascavel-PR, Brazil, due to its easy access for the researchers, and the fact that this region of the State has not been frequently addressed in health area studies. This Regional District along with 22 others comprise the intermediary management sectors of the State of Paraná Health Department along with the municipal health departments in the state.⁶

Since there can be a certain diversity among Family Health teams in the cities within this regional district due to their population size (differentiated capacities in FHSs to provide health care that may influence the possibility of providing longitudinal care), in order to define the participants in this study, these cities were therefore divided as follows: cities with less than 5,000 inhabitants (six); between 5,000 and 10,000 inhabitants (ten); between 10,000 and 20,000 inhabitants (seven); between 20,000 and 35,000 inhabitants (one city); and with more than 35,000 inhabitants (one city). Afterwards, two cities were drawn from the first three groups and the two larger groups were included. Hence, the research was performed in seven of all 25 cities that compose the 10th RH.

In the selected cities, among nurses working in the FH units, from urban and rural areas (total of 27), twenty nurses who accepted to participate in the study and were within the inclusion criteria: being part of a complete FHS team, being in this team for at least one year and not being on absence leave at the time of data collection were selected. It is also important to point out that at the time the study was performed; many cities were going through difficulties in maintaining their FHS teams, due to professionals' turnover. Therefore, in order to make this study feasible, nurses' working time in the team was reduced to around six months, because we considered their previous experience in other health teams useful.

A semi-structured interview technique was used for the collection of empiric material. Interviews were performed in April of 2010, after previously booked by telephone, according to each professional's availability. They were recorded after their consent with a digital recorder. In order to perform these interviews a guiding script was followed, consisting of two parts: the first with objective questions regarding the sociodemographic profile and the researchers' work dynamics; the second part with open-end questions regarding their perceptions about the difficulties in providing longitudinal care to clients and the ways to overcome the difficulties presented.

Data were analyzed by means of category content analysis, where the pre-analysis was performed through brief readings of the collected data composing the analyzed *corpus*, guiding initial questionings and interpretations. Exhaustive readings, coding, numbering, classification and material aggregation were performed. Interest units were identified from common aspects among them and inferences.⁷ Interpretation and categorization were then executed on the obtained data, and discussed based on scientific literature approaching FHS and the work of FHS nurses, according to Starfield's⁴ framework about longitudinality.

This study followed the ethics concepts for human research guided by Resolution 196/96 of the National Health Council, with the approval of the Permanent Ethics Committee for Human Research at Universidade Estadual de Maringá (Review number 659/2009). Before the interview, the researcher explained all the informa-

tion regarding the study to the participants and they signed a Free and Informed Consent Form. In order to differentiate and preserve nurses' identities the letter 'N' followed by an Arabic number was used according to the interviews order (N1 to N20).

RESULTS AND DISCUSSION

Learning about the nurses in this study

From the 20 nurses interviewed, nearly all of them were female (19), between the ages of 22 and 45, mostly married (12) and without children (11). Eighteen were working only in the FHS, one also in the teaching area and one in the hospital area. Family monthly income ranged between three and twenty-three minimum wages, most individuals (14) ranged between five and ten minimum wages.

Most (13) nurses graduated in public universities, and the time since graduation ranged between two and twenty years. Fourteen nurses had graduated less than eight years before. Nineteen nurses had a *lato sensu* graduate degree, 15 in the public health area, and only five in the Family Health area.

Most professionals (15) worked exclusively in FHS, and 17 were associated to the service by public examination. The time working in FHS ranged between five months and 11 years, and the working time in the current unit between five months and eight years, mostly (10) in the range between one and five years.

Most FHS teams (17) followed a pre-settled number for this care model, providing care for 500 to 1,000 families. From the total number of nurses interviewed, twelve had some part of their area not covered by HCA.

Elements that can make longitudinality difficult and the possibilities for overcoming

Although FHS proposals hold developing health promoting actions and disease prevention as priority, nurses point out difficulties due to the fact that, many times, the health team is focused on curative actions and the population is still used to the traditional health care model, a model focused on the disease is strongly present in the professionals and clients routine:

[...] the curative care is still broadly provided, and to improve, it must go towards prevention and health promotion, priorities for FHP. Curative care is developed at the moment and will be forgotten, it is not continuous. In promoting and preventing you will always be following up, even when you have to perform curative care once in a while, but if you can provide prevention care along with it, it's much better (N2).

[...] the population still holds a very curative view, they want medication, they don't prevent so much and do not adopt more natural methods to care for problems, they want a lot of medication [...] But they should think different, understand that preventing is better (N19).

Findings demonstrate that nurses understood the need for changes, since the FHS Proposals, in some cases, were not yet effective and that by following those, proximity between professionals and clients can be promoted and establish ties configuring this care providing model as excellent to accomplish longitudinality in the primary level of care. Therefore, health professionals must perform a quality practice with the capacity to stimulate the population into searching for better health conditions, viewing people under their full bio-psycho-social, economic, cultural and spiritual conditions.⁸

Providing care beyond aspects involving the cure of a pathology benefits longitudinality, for this reason, interviewees understand that a change in the population's view would be a way to promote this care, although it demands time and efforts from the team, valuing preventive actions and establishing ties in a way that clients may perceive the positive impacts on their health and become gradually used to it, accepting and acting according to the FHS principles.

Among reports, a specific situation standing out in the larger city in this study was identified: at the time of data collection, there was only one FHU in the urban area, composing difficulties for nurses to work:

[...] I see that to improve health actions and to have this long lasting care, the population's view must be changed, it takes a long time, especially because we are the only ones in the city, the population doesn't understand that. FHP had to be implemented all around the city, and then everyone would be talking the same language (N16).

From this excerpt, we understand that clients search other services or they do not accept/understand FHS, therefore the long-term relationship is damaged, because professionals have less contact with clients, limiting the identification and solution of problems. Hence, we can infer that with the implementation of FHS for the whole population, its principles would be widely more effective, enabling clients to adjust to care focused on health. According to literature, many clients are not satisfied and have difficulties in understanding the FHS Proposals. Moreover, medical appointments are not booked.⁹ Many, therefore, prefer the PHUs (Primary Health Units) that have more available doctors and specialists.

Regarding the nurses in this study, five were working in mixed health units; therefore they presented the suggestion of improving the care for clients, asking for the creation of an exclusive FHS unit with the appropriate physical structure to follow the policies of this care model:

[...] well, here everything is very mixed... there should be a separate FHU, according to the FHP, and this team should unite like that and provide service only for the unit's reach (N7).

[...] we would like the PHU and the FHU to be separated, because what we do there is not FHP, we provide service for demand and we do nothing in prevention, I think it gets in the way... (N8).

When FHU and PHU work in the same health unit, the traditional model tends to prevail because it is stronger in the roots of professionals and clients' routines. As an exclusive FHU is created, the team has higher possibilities to make FHS Proposals effective and consequently accomplish longitudinality, since this model's characteristics favor it. For this, financial, technical and political incentives are necessary to the basic health network of the country, because infrastructure investments are urgent and it is necessary to promote the remodeling and constructions of health units that can provide health to the family.

From nurses' reports, we understand that, many times, work is not integrated; thus constituting a factor that tends to limit longitudinal care for clients:

[...] the team is not integrated, so this makes our work difficult, the CHA doesn't visit us, it hinders a bit (N7).

[...] *the team is something that can contribute or hamper. The team is not fully integrated, unfortunately; there is always something, it not easy to keep solving things that make things difficult. I have difficulties even with the CHA in some areas, and also with the areas that are not covered by it* (N18).

In FHS the multi-professional work is essential so that proposals of the care model can be effective, and when it does not happen, actions are damaged, and a fragmented care is offered to clients, preventing them from having interpersonal relations with the whole team and the longitudinal care is therefore in the hands of few professionals, or it is not even provided.

Literature points out that, in general, the health team is participative and there is more collaboration and involvement of the HCA in following-up clients throughout time, creating professionals that better know the population's reality. On the other hand, other team members are not effectively involved. The doctor is the least integrated professional in interdisciplinary actions, focusing his actions on the traditional model.¹⁰

Professionals working in FHS must gather their knowledge in order to provide the population a humanized care based on the Unified Health System (*Sistema Único de Saúde - SUS*) principles, and it is essential that each team member is willing to share objectives, decisions, responsibilities and results.¹¹

In view of the appointed difficulties, nurses report that the main strategy in dealing with it is that FHS professionals need a specific profile to work this care model and act according to its policies:

we must have the profile. Many take it due to a lack of options, because they are approved in the public tender, people who say that FHP won't have many problems, it is easy. I think that [...](N7).

to improve the lack of follow-up to clients, a work according to the FHP must be developed, and also we should have a complete team made of interested people (N12).

In FHS, it is essential that the professional is willing to work for the community, since in this model the team is not restricted to working only at the FHU and to the individual, but also to the main purpose of this work, understanding the whole context in which the client is inserted, developing their work focusing on the family

- which generates its importance - and parting from a multi-professional and interdisciplinary work.

Moreover, some nurses affirm that professional training is a resource that could improve healthcare throughout time, involving both working the FHS and the team's work under the longitudinality perspective. We point out that only five among the interviewees reported having received some type of guidance to work in the FHS, a limiting factor to understand and develop actions according to this model's principles:

[...] *I never had any training to work in the FHP, I should have, and I think that if there was a training that would cover the whole team, it is important; this prolonged care would be a strategy* (N8).

[...] *follow-up would be improved throughout time if a more aware work was performed with the whole team, that the nurse, sometimes, ends up trying to do things, but can't do it, but this way, with a work more within the team, a training to learn how to maintain the work [...]*. (N11).

Nurses are correct when they affirm that exposing professionals to the importance of the longitudinal work is a strategy for them to continue the actions under this perspective and to improve, since it is essential for them to understand its benefits in order to commit to its execution. If professionals are appropriately prepared to work in FHS and develop their action according to the purposes of this care model, longitudinality will occur, since FHS predicts this closer relation to individuals, families and the community, especially by establishing ties and full care delivery.

Training must occur before structuring the team, since its activity is improved as the work routine is developed under guidance and attendance of the unit nurse and meetings among professionals to discuss conducts and therefore provide a better quality care delivery, allowing for them to understand better objectives and strategies.¹²

Some nurses also referred to the availability of resources (human, physical and material structure), condition that composes an important care quality factor and effectively establishes longitudinality. Most of interviewees pointed out that they did not satisfactory counted on these resources, and they pointed investments by the FHUs as the solution:

there is a difficulty in the lack of professionals, in not having all areas covered by CHA, because we end up not knowing what is going on in that area, in the lack of a car for the team, lack of material, beds, divisions, a lack of everything, the basics to provide care for the patient. We need more budget; hire more CHAs, to have more conditions (N5).

[...] a better physical structure would improve it. There is no privacy, no rooms only for the nurses. Also there is no financial part. If there was a car available for the FHP, since this is a mostly rural area... didactic material, some investment, wow...it would help a lot (N7).

Difficulties expressed by these interviewees can describe how precarious care delivery for the client is, since it makes quality care delivery, the suitable follow-up to clients and solving problems difficult. In addition, the tie between the population and FHS professionals can decrease and make, in many cases, people search for other care levels in order to fulfill their needs. In the same way, when ties are established, following -up throughout time is favored, leading the population to identify in the FHU a regular source of care.⁴

An available car was the main complaint from nurses in this study, since this is an essential resource for maintaining a frequent contact among clients and the team, opening the opportunity for the team to perform house calls and community visits, especially in cases where the FHS is in a rural area. Similar data were found in literature, pointing out that FHS teams face difficulties in providing care delivery especially regarding the lack of material resources, as in the case of a deficient transportation system, mainly due to the fact that a significant part of the population resides in the rural area.¹³

Some nurses mentioned, regarding human resources, that they were overloaded with work, especially because they were responsible for managerial issues in the FHU. The only improving strategy seen by them was hiring more professionals:

[...] look, I think there are difficulties because the nurse is responsible for the team, the paperwork, and the reports. Lately, I've been doing much more coordination than care delivery. I have no position, coordination through the secretary, but I respond for everything, if the car breaks down, if the fan is not working, employees vacations [...]. It is an overload

for the coordination, I am unhappy because I leave care delivery set aside [...]. Maybe hiring someone just to coordinate would help (N18).

With functions accumulation, nurses tend to perform activities that require urgent responses, keeping them distant from the population's reality. This hinders providing a quality care that will mainly meet comprehensiveness of actions and therefore the frequent contact and tie with clients is damaged, disabling longitudinal care delivery.

The lack of professionals in the FHS team hinders the work, and when actions have a care feature, in many cases, professionals cannot be substituted and this difficulty may overload other team members in performing activities, resulting in problems in the care delivery for the population.¹⁴

Another important point is highlighted by one of the interviewees regarding FHS professionals turnover, a fact that mainly happens due to low salaries; therefore the improvement proposal would include salary review, motivating professionals to work and therefore stay longer with the same population:

the salary is too low, so the turnover is high, nurses, pharmaceuticals professionals, dentists; they all have the same low salary. People stay because they have no other option, when they find better jobs they leave [...]. The salary had to be better, then people are motivated and they don't leave (N5).

Turnover among FHS team professionals is a factor that can disable care delivery throughout time since it damages the establishing of ties with the community, limits earning their trust and consequently, continuing those actions. Therefore clients' knowledge is damaged, limiting the elaboration of actions that are more congruent to their reality.

A study performed in Vale do Taquari-RS pointed out a turnover of 20% to 40% of active professionals in FHS in the period of 2001 and 2005, and the main causes are precarious work ties, education fragmentation, authoritarian management style, the lack of ties to the community and bad working conditions.¹⁵

In the same way, establishing good interpersonal relations between professionals and clients is essential, and due to the difficulty in establishing this connection the care throughout time is damaged:

[...] a family that the team took more than a year to register. They have many different problems, high blood pressure, the son is bulimic. In the beginning of this year the CHA was able to register, and the social worker was in their house once, but very briefly. I think that if we had made contact with this family sooner, maybe the boy would not be in this condition, he had to be admitted to the hospital due to his bulimic state (N20).

The lack of a suitable attendance throughout time can be a factor that contributes for grievance in people's health condition. The previous report was an example for this, since actions could not be effective in promoting health and preventing diseases in the initial phase of the disease process, causing the individual's health to aggravate, consequently needing to use more complex services.

In locations where there is a suitable PHC attendance, health quality of clients is improved, resulting in higher prevention of diseases and deaths, as long as there is a demand for quality professionals and a good relationship between clients and the health team. Benefits are mainly the increased life expectation, reduction in general of newborns' mortality and low weight at birth and the search for emergency services¹⁶.

In their reports, some nurses still mention problems regarding accessibility, configuring a limitation in performing care throughout time, involving access both for clients to the unit and professionals to their homes and communities:

the problem is the access, distances range up to 30 kilometers from one community to another [...] And it is difficult for the population to come to the unit, because there is no public transportation and many have no car [...] For this reason there should be one more car made available for patients, more resources in the transportation sector (N14).

there is the difficulty in accessing the country side, in rainy days roads are bad, then we cannot go and they cannot come [...] I don't know, we ask for road maintenance (N15).

Difficulties presented here were mentioned by nurses who worked in a FHU located in the rural area, where the distances among houses are great and roads are not always in good conditions; that is the reason why nurses suggest changes and improvements in road conditions and public transportation.

Lack of access limits the contact between professionals and clients and care delivery, therefore

establishing a lasting relationship is damaged. Hence, accessing healthcare in SUS involves economic, technical care provision, political and symbolic dimensions, and in order for accessibility to occur, the available resources for transportation, dislocation time, distance and costs must be considered.¹⁷

Under this context a symbolic aspect that defines access must be highlighted, since, "when depending on health concepts, sickness and the health/sickness process, different intervention paths can be planned in order to guarantee the client's entrance in healthcare".^{17:168} The symbolic dimension is a broad vision of the health/sickness process, and it is composed of social representations of healthcare and health services.¹⁷

Also, healthcare is, many times, damaged by the absence of information regarding the care provided to clients within another level of care delivery, in other words, within situations that the counter-reference system does not work in a satisfactory mode:

[...] I have an elderly, diabetic, high blood pressure patient who always came to appointments. One day, we sent him to the reference center for treatment where he was admitted for a while, when he came back, he didn't know what happened to him. He went back home and we kept his case under close care; we had to see him even on the weekends. Even today we have to see him, he is better, but cannot explain what happened (N6).

When clients are admitted to a higher complexity services, this procedures should be sent back to the FHS team, enabling those professionals to learn about the whole process of health care delivery and therefore follow-up the case with a better perspective of the health/sickness process. This, therefore, favors the continuity of care delivery, promoting higher solving features and longitudinality to the care.

PHC reorganization foresees the functioning of an efficient reference and counter-reference system, as well as partnerships between public and private institutions and between many care levels. Flaws in this process damage the continuity of care delivery and hinder the implementation of SUS principles and guidelines.¹⁸

FINAL CONSIDERATIONS

The development of this present study followed the proposed objectives and allowed for

identifying a number of difficulties that limit its execution and longitudinal care, approaching issues as persistence of the curative model in the professionals and clients' routine, difficulties in team work, lack of resources, difficulties in establishing ties between professionals and clients, in addition to access problems to the counter-reference system. Under this context, it is essential that these difficulties be overcome, so that longitudinality can occur and its benefits can be accomplished. This way, nurses pointed out the importance of executing FHS principles by professionals' commitment and preparation and by the acceptance and understanding of this care model by clients. Moreover, more FHUs investments are needed (material, physical structure and human resources) and the improvement of ties between professionals and clients and the rural road conditions, in addition to the implementation of a quality counter-reference system.

The difficulties involving longitudinal work must be highlighted and the propelling elements of change are essential so that nurses as the whole FHS team can understand the importance of longitudinality, the ways to perform it and improve it within professional routines.

We hope that this study results can contribute for longitudinality in healthcare to be a reality in care practice and therefore the population can gradually benefit from it.

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