DOI 10.18471/rbe.v32.18319

STRATEGIES OF WOMEN BEFORE THE LOW PROBLEM-SOLVING CAPACITY OF PRIMARY HEALTH CARE

ESTRATÉGIAS DE MULHERES FRENTE À BAIXA RESOLUTIVIDADE NA ATENÇÃO BÁSICA À SAÚDE

ESTRATEGIAS DE MUJERES FRENTE A BAJA RESOLUCIÓN EN LA ATENCIÓN BÁSICA DE SALUD

Andiara Rodrigues Barros[1]
Edméia de Almeida Cardoso Coelho[2]
Amanda Calila Cunha Barradas[3]
Rosália Teixeira Luz[4]
Maria de Fátima Alves Aguiar Carvalho[5]
Priscylla Helena Alencar Falcão Sobral[6]

How to cite this article: Barros AR, Coelho EAC, Barradas ACC, Luz RT, Carvalho MFAA, Sobral PHAF. Strategies of women before the low problem-solving capacity of primary health care. Rev baiana enferm. 2018;32:e18319.

Objective: To analyze the strategies adopted by women before the low problem-solving capacity in their area of Family Health Strategy coverage. Method: This was a qualitative study that adopted comprehensiveness as its analytical category. Interviews were conducted with 12 women of reproductive age and who were registered in one of two Family Health Units. The empirical material was analyzed using technical discourse analysis. Results: The search for higher complexity services was the main strategy adopted by women to care for their demands in the absence of response from primary care. This network was adopted as their reference given the lack of primary network infrastructure to effectively play its role and thus the Family Health Strategy program is only occasionally sought out. Conclusions: In light of the inefficiency of the Family Health Strategy, the specialized network is these women's first choice, inverting the roles of health services, which strengthens the curative care medical model, in opposition to the principles of the Unified Health System, and denies comprehensiveness of care.

Descriptors: Family Health Strategy. Primary health care. Women's health.

Objetivo: analisar as estratégias adotadas por mulheres frente à baixa resolutividade em área de cobertura da Estratégia Saúde da Família. Método: estudo de abordagem qualitativa, tendo a integralidade como categoria analítica. Foram entrevistadas doze mulheres em idade reprodutiva e cadastradas em duas Unidades de Saúde da Família. O material empírico foi analisado pela técnica de análise de discurso. Resultados: a busca por serviços de maior complexidade constitui a principal estratégia adotada por mulheres para atendimento de suas demandas na ausência de respostas da Atenção Básica. Incorporam essa rede como referência diante da falta de infraestrutura da rede básica para efetivar o seu papel e a Estratégia Saúde da Família passa a ser lugar de procura eventual.

[1] Nurse. Master's degree in Nursing. PhD from the Nursing Graduate Program, Universidade Federal da Bahia. Salvador, Bahia, Brazil. andiarabarros@gmail.com
[2] Nurse. PhD in Nursing. Adjunct Professor at the School of Nursing of the Universidade Federal da Bahia. Salvador, Bahia, Brazil.
[3] Nurse. Salvador, Bahia, Brazil.
[4] Nurse. PhD degree in Nursing. Master's degree in Public Health. Assistant Professor at the II Department of Health of Universidade Estadual do Sudoeste da Bahia. Jequié, Bahia, Brazil.
[5] Nurse. PhD student at the Nursing Graduate Program of the Federal University of Bahia. Professor at the Universidade Federal do Vale do São Francisco. Petrolina, Pernambuco, Brazil.
[6] Nurse. Master's degree in Nursing. Professor at the Universidade Estadual do Oeste do Paraná, Cascavel Campus. Cascavel, Paraná, Brazil.

Conclusões: diante da inoperância da Estratégia Saúde da Família, a rede especializada passa a ser primeira escolha das mulheres, numa inversão de papéis, que fortalece o modelo médico assistencial curativo, contraria as diretrizes do Sistema Único de Saúde e nega a integralidade.

Descritores: Estratégia Saúde da Família. Atenção primária à saúde. Saúde da mulher.

Objetivo: analizar estrategias adoptadas por mujeres frente a la baja resolución en área de cobertura de la Estrategia de Salud Familiar. Método: estudio cualitativo, teniendo la integralidad como categoría analítica. Se entrevistaron a doce mujeres en edad reproductiva y catastradas en dos Unidades de Salud Familiar. Material empírico analizado por la técnica de análisis de discurso. Resultados: la búsqueda de servicios de mayor complejidad constituye la principal estrategia adoptada por mujeres para atender sus demandas en la ausencia de respuestas de la Atención Básica. Incorporan esa red como referencia ante la falta de infraestructura de la red básica para ejercer su papel y la Estrategia de Salud Familiar se torna lugar de búsqueda eventual. Conclusiones: ante la inoperancia de la Estrategia de Salud Familiar, la red especializada constituye la primera elección de las mujeres, en una inversión de papeles, que fortalece el modelo médico asistencial curativo, contraria las directrices del Sistema Único de Salud y niega la integralidad.

Descriptores: Estrategia de Salud Familiar. Atención primaria de salud. Salud de la mujer.

Introduction

In the Brazilian Unified Health System (SUS), health care is divided into three levels of complexity, forming a pyramid, with primary care at the base and secondary and tertiary care, higher complexity levels, in the middle and at the top, respectively. Primary care, considered the entryway into the health system, is supposed to meet 80% of the population's demands[1]. For more complex demands, the system should ensure referrals and counter-referrals to specialized outpatient and hospital services[2].

The role of the Family Health Strategy (FHS) is to reorganize primary care and respond to the demands of users through actions to promote health and prevent diseases, referring all cases that surpass their scope of action and problem-solving capacity to higher complexity levels.

However, within the scope of women's health, history has shown that the search for care is laden with discrimination, frustration, and the violation of rights, representing a source of psycho-physical tension and discontent. In Brazil, epidemiological indicators relative to women's health indicate that despite the existence of public policy and health actions, regional inequalities contribute to increasing female vulnerability[3].

In the FHS, problems of structural order, relative to how services are organized, pervade health practices. Thus, on a daily basis, women still face obstacles to meet their demands, generated in a context of social inequalities[4-5].

This reality is expressed through lack of care comprehensiveness, a measure that requires embracement, sensitive listening, access, and problem-solving capacity. In this approach, professionals must contextualize the experiences of women, respecting their singularities. However, a great number of women who use the public health system are in a position of social and economic vulnerability. Being an FHS user does not ensure access and problem-solving capacity, and thus the changes required still face many limitations[6].

Studies that have investigated the experiences of women when searching for care within the FHS coverage area have exposed the mismatch between care demands and the answers provided by the FHS. Users have experienced low problem-solving capacity, attributed to team discontinuity, high professional turnover, in addition to lack of infrastructure and user embracement. Consequently, users distance themselves from this level of care and seek out services that work at intermediary- and high-complexity levels[4-5].

The present article was extracted from a dissertation called "Health Demands and the Experience of Women Registered in the Family Health Strategy in the Search for Healthcare" (*Demandas de Saúde e a Experiência de Mulheres Cadastradas na Estratégia Saúde da Família na Busca pelo Cuidado*). The aim of the study was to assess the strategies adopted by women before the low problem-solving capacity found within the scope of the area covered by the Family Health Strategy program.

Method

This was a qualitative descriptive study developed in the areas assigned to two Family Health Units in the Health District of the city of Salvador (Bahia), Brazil. Comprehensiveness was adopted as the analytic category, which consists of the person's right to care according to their needs, and the duty of the State to provide organized health services to comprehensively meet these needs.

Twelve women of reproductive age participated in the study, according to the following inclusion criteria: 15 to 49 years old; registered at the FHUs included in this study, and who were not regular users. There were no exclusion criteria.

Participants were between the ages of 27 and 49, predominately in the age group 30 to 40 years. Most declared being black, and one self-declared as Asian. Five women were married; four, single, and three; in a common-law marriage. In terms of level of education, five had completed secondary education; four had incomplete secondary education; and three, incomplete elementary education. Seven women had a paid job, of which six earned less than a minimum wage per month. Their partners were the main person responsible for the family income. The other women were homemakers.

To carry out this study, the management of the family health unit was contacted previously to request permission and the collaboration of community health workers to facilitate access to women and schedule interviews. Semi-structured interviews were used to produce empirical data, conducted through guiding questions. A pilot test was conducted with four women to assess the tool and make any necessary adjustments. The number of participants was defined during the study, when recurrences, redundancy, and repetitions became frequent, ensuring that the collected empirical data met the aims of the study. Data collection was carried out between September and November 2012. The results are presented using excerpts from the interviews.

The empirical material was analyzed using discourse analysis according to Fiorin[7], following these steps:

1) Reading of full text, locating recurrences, i.e., figures (concrete elements) and themes (abstract elements) that led to the same level of meaning, so as to ensure coherence.

2) Grouping data according to meaningful elements (figures or themes) that add up to or confirm a same level of meaning.

3) Defining the central themes and formulating subcategories that result in the construction of one or more central empirical categories.

4) Analysis and discussion of empirical categories guided by the theoretical axis, according to the pertinent literature.

The central empirical category gave origin to the title of the present article.

The present study was approved by the Research Ethics Committee of the UFBA School of Nursing, under ruling no. 92.069. It abided by the bioethical principles in Resolution no. 466/12 regarding autonomy, slander, justice, veracity, and reliability. The interviews were conducted after obtaining consent from participants who received explanations about the study and then signed informed consent forms. The participants were assigned fictitious names.

Results

Primary care demands that were not met by the FHS, within the context of this study, resulted in women adopting the specialized care network as a strategy to obtain access and

problem-solving capacity of care. The following excerpts illustrate this point:

> *So, we get preventive care work done, but not all, just a part of it. To get complete preventive care, you have to go somewhere else* [...] *I think they should at least do that and do other tests, such as blood, feces and urine, so we don't have to go somewhere else, leave here and go somewhere else.* (Juliana).

> *First of all, there are no doctors* [...] *I go to other places because they have nothing to give here, for my needs* [...] *before, when they still wrote requests, when you could talk to a nurse and she would give you requests for tests, but because I…have never been seen by a doctor, I went after other units.* (Márcia).

> *At the places we go, they are always quicker to provide care, they schedule consultations closer to what we want.* (Marina).

The participants emphasized hospital institutions as places with higher problem-solving capacity. Access was still considered difficult, and they had to face early mornings to schedule appointments:

> *I get up very early to leave the neighborhood, because the hospital is far away, I have to get a bus to get there* [...] *We even risk our lives! We get there when it's still dark, sometimes we're able to get there at 6 in the morning, and there's already a long line, and frequently* [...] *there are no more openings. I try again, I get up even earlier the following morning* [...] *sometimes we get there at 4 AM and we still can't schedule an appointment, because there are already so many people.* (Taís).

> *We have to go after preventive care; we have to go somewhere else, you know, the hospital* [...] *there are no actual lab tests here, we have to go somewhere else to get them, which means waking up at four in the morning, grabbing the first bus, that sort of thing.* (Joana).

Unaware of the FHS's proposal, they expected it to provide a wider scope of care technology capable of screening for pathologies, as shown in the following excerpt which represents the voice of several participants:

> *We cannot count on this place to get our routine tests, preventive tests* [...] *I go to the* [hospital] [...] *I need to get a mammogram, and then I have to get a breast ultrasound, and I never got one. They perform pap smears, but you can't get a transvaginal ultrasound* [...] *I grab my request and go get the tests done at* [hospital 1], *or* [hospital 2]. [...] *I have high cholesterol, so I think I need to see a specialist to take care of this disease* [...] *just now I did my blood work and my triglycerides are very high. They have no doctors up there* [...] *I also prefer going to the doctors outside here, because I don't know about here.* (Carla).

Successively seeking out the public system without obtaining access was one of the reasons reported by women for adopting private services as their reference:

> *Every time I go, they can never schedule tests* [...] *Because of these difficulties* [...] *like the absence of nurses, I prefer just going into town already. And some tests are hard to find through the SUS. When we need to pay for them, it's absurdly expensive* [...] *I go somewhere else, I look for another place, or else I have to find a way to pay for the tests.* (Sandra).

> *They don't do tests here, we can only get them done if we pay for them, because through the SUS, it is very difficult* [...] *The service is poor, and it takes such a long time that we are even willing to pay for them if we can, because if we're sick and rely only on public health care, we're going to die, because there are no tests.* (Taís).

> *Sometimes we're looking for an ear-nose-throat doctor, or a cardiologist, it's hard. Most of these doctors we have to pay for* [...] *We hear about other clinics* [...] *When those places become popular for carrying out tests, the SUS cuts them off.* (Sandra).

> *Since we pay taxes that go to the SUS, they should provide better services. So, this is where we stand; it is quite hard for us, financially, because we can't afford it. We pay with our sweat, when the public care unit should be providing these services.* (Beatriz).

> *If access is not simple, I prefer to pay for care...and I give up doing something else* [...] *It's not like I can afford it, not at all. But health comes first, so I have to pay* (Maria).

> *It is so hard* [...] *We have to choose what to sacrifice* [...] *We don't always have money in hands to take care of ourselves* [...] *Right now, for example, I'm going to pay sixty Reais for a private consultation* [...] *We go there, and find closed doors and receive no care, or when we can get care, we are treated poorly, right?* [...] *So where do we go? Where can we turn to? In what direction? Only God can help us, only God.* (Márcia).

Discussion

The interviews showed that in the studied reality, low problem-solving capacity contributes to the FHS no longer being a reference of primary care. When their demands are not embraced, the women seek out high-complexity services in line with the doctor-centered model, and the FHS program, lacking in infrastructure to carry out its proposal, is only sought out occasionally. Because of the low problem-solving capacity of the FHS in the studied area, the specialized network is strengthened, and primary care is increasingly discredited[7].

Studies have shown that the search of FHS users for other services is associated, above all, with geographical obstacles regarding the unit's location; difficulty in accessing medical care;

shortage of professionals to meet the demand; and the work organization in the services[8-9].

The results of the present study showed that the women have constructed a history of frustration with the FHS, because of its low problem-solving capacity, strongly marked by the absence of physicians, and high nurse and dentist turnover rates. Another contributing factor was the precarious condition and lack of material infrastructure to provide supplies, such as drugs, dental material, and routine tests[5].

In a context of uncertainty and risks, the women in the study woke up early in the morning to attempt receiving care at high-complexity services. On receiving satisfying answers to their clinical complaints, they created their own reference network, electing services to which they could entrust their needs. Thus, the roles of the services that compose the reference network are altered inverting the SUS pyramid, in which primary care is at the base, and intermediate and high technological complexity care levels at the middle and top, organizing the flow of users through a system of referrals and counter-referrals.

Mechanisms of interaction and integration among healthcare complexity levels create adequate user flow, ensuring users' right to access, providing immediate interventions, continuity of care, and timely prevention, through the use of the primary care support and the reference network[10]. Individuals referred to higher-complexity levels must be counter-referred, i.e., sent back to their units of origin to ensure continuity of care[11].

The present study showed that such referral and counter-referral processes were absent and thus, the SUS and FHS disfigured, with women experiencing disrespect and humiliation. Under their personal responsibility and devoid of freedom and power of decision, they attempted to access a complex structure, which is not suited for most of the demands presented in the interviews.

Wait time for consultations in intermediate-complexity services was also a barrier to access. In a study that investigated the role of primary care, access to intermediate- and high-complexity services stood out as a considerable barrier, while also constituting an object of desire. Among other factors, this is caused by long wait times and lack of knowledge about the actions developed[12].

This reality illustrates that the process of implementing the FHS and the territorial model do not abide by the principles that should guide the organization of primary care. The concentration of family health teams in a single unit, with the goal of ensuring coverage of large territories, has also been a problem, causing difficulties in geographical access[9].

Based on the principles of the SUS, the key point of the FHS proposal is to reorient the care model through primary care. Among the SUS principles and guidelines, comprehensiveness is the one that relies on the others to be reached. Thus, in order for comprehensiveness of care to occur, it must be practiced in the actions and attitudes of all those inserted in the process[13].

Long wait times contribute to the discredit of the FHS and hinder access to services. Furthermore, problems in service organization, lack of human resources, and difficulties in continuity of treatment represent further barriers. The prevalence of the biomedical model and lack of critical analysis emerge as limiting factors, preventing the population from recognizing and incorporating health as their right, which would reduce their expectations about the results of primary care[8].

In the present study, unsuccessful successive returns to the public health system, whether at the primary or higher-complexity care level, placed the women in the difficult situation of compromising family resources to use the private network. Nonetheless, most were part of the lower income population, and under these circumstances, they almost never sought out the FHS program. Their discourse revealed that in the absence of effective SUS action, they submitted themselves to the system that commercializes health care.

Individual and curative health care has taken the lead role in the production of health

services. This model places a high value on medical specialties, with the use of complex technology, whose access is encouraged to the entire population, upstaging primary care actions and hindering the view of human beings in their singularity and how they are inserted in the collective space. Consequently, health care is limited to complaint-conduct procedures, which do not contribute to overcoming the hegemonic care model[14].

In a health system strongly guided by market interests, comprehensiveness faces numerous challenges to becoming the guiding axis around which the services and health practices are organized, even though it is one of the principles of the SUS with great potential to improve quality of care. Factors that contribute to this scenario include the biomedical framework of professional education, which fragments individuals and the health system and the way patient flow and solutions are organized[15].

However, consolidating comprehensive care is a complex task and depends on professional practice and service staff sizing. Teams lack time to plan activities, and there are professional limitations in carrying out procedures, as well as lack of adequate structure to meet patient needs[16].

Throughout history, several financial and health provision services have been used in both the public and private health system. The private sector, through strategic coordination, remains strong, and far from complementing the public system, it invests in a highly profitable market, vigilant of the gaps left behind by the public sector. The health system's dependence on private services and difficulties of access throughout the network help expand health iniquities and deprives the population of comprehensive care[17].

Within the context of this study, public authorities have stripped primary care of its problem-solving capacity. On its failure to establish itself within the health system as per its proposal, the FHS represents an obstacle to reconstructing primary care and its valorization, destabilizing the pillars that support the medical specialties and technology on which it is based.

While the curative medical care model grows stronger, FHS loses its role as the main responsible entity for health promotion, disease prevention, provision of low-complexity care, and for being on the ground, close to the population and its needs, establishing relationships between professionals and users according to its directives. Ideally, the FHS would present solutions and improve the quality of life of the population in each area, ensuring embracement, access and problem-solving capacity, and effectively become a reference and counter-reference network, and consequently, quality relationships between users and teams and services, which translates into comprehensiveness.

Conclusion

The women who participated in the study came from lower-income populations with limited social opportunities. The FHS is primarily aimed at this population, recognized as a strategy with great potential to reorganize primary care and consolidate the SUS.

The results show that primary care services, whose purpose is to work with disease prevention and health promotion, are affected by lack of priority given to these actions by public authorities, which widens the gap for women who are socially and economically vulnerable. Citizens are denied their right to health, with no guarantee that they can access professionals and actions that can meet their needs.

The specialized network is an alternative strategy chosen by the women, as it is considered capable of providing access and providing answers, representing their first choice. This inverts the roles of services, in opposition to SUS and FHS principles. When it is transformed into the reference for health care and problem-solving capacity, the clinical and biomedical model is strengthened, turning the population away from the perspective proposed by the FHS and SUS principles.

Another strategy used to navigate the health system when the SUS could not deliver its promise was to seek out private sector services, when the women could afford to do so. When they reached the point of seeking out the private network, they have basically given up on the FHS, being discouraged by numerous unsuccessful returns to the specialized public network. This context fosters the commercialization of health care and socially legitimizes its maintenance.

The situations described by the participants revealed barriers that are difficult to overcome, because of the working conditions of the services, leading to lack of comprehensiveness of care. Removed from its main function, the FHS is not able to provide women with the necessary care, and neither is it able to be recognized in its purpose within the SUS.

There is a pressing need to reorganize and recover the principles of the SUS, ensuring effective multiprofessional teams. Public authorities need to provide family health units with the necessary physical, human, and material infrastructure to ensure the problem-solving capacity of its actions, which favors the establishment of bond with women, and provide the comprehensive care they currently lack.

Collaborations

1. conception, design, analysis and interpretation of data: Andiara Rodrigues Barros, Edméia de Almeida Cardoso Coelho and Amanda Calila Cunha Barradas;

2. writing of the article and relevant critical review of the intellectual content: Andiara Rodrigues Barros, Edméia de Almeida Cardoso Coelho, Amanda Calila Cunha Barradas, Rosália Teixeira Luz, Maria de Fátima Alves Aguiar Carvalho, and Priscylla Helena Alencar Falcão Sobral;

3. final approval of the version to be published: Andiara Rodrigues Barros and Edméia de Almeida Cardoso Coelho.

References

1. Brasil. Ministério da Saúde. Conselho Nacional das Secretarias Municipais de Saúde. O SUS de A a Z: garantindo saúde nos municípios. 3ª. ed., 2ª. reimpr. Brasília; 2009. [cited 2016 Jan 13]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/sus_az_garantindo_saude_municipios_3ed_p1.pdf

2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes. 2a reimpr. Brasília; 2011. [cited 2015 Dez 1]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_mulher_principios_diretrizes.pdf

3. Brasil. Conselho Nacional de Secretários da Saúde. Assistência de média e alta complexidade no SUS: coleção para entender a gestão do SUS. Brasília; 2011. [cited 2015 Dez 12]. Available from: http://www.conass.org.br/bibliotecav3/pdfs/colecao2011/livro_4.pdf

4. Sousa JJ. Circunstâncias da ocorrência da gravidez não planejada em mulheres usuárias do Programa de Saúde da Família [dissertação]. Salvador (BA): Universidade Federal da Bahia, Escola de Enfermagem; 2011.

5. Barros AR. Demandas de saúde e a experiência de mulheres cadastradas na Estratégia Saúde da Família na busca pelo cuidado [dissertação]. Salvador (BA): Universidade Federal da Bahia, Escola de Enfermagem; 2013.

6. Coelho EAC, Andrade MLS, Vitoriano LVT, Souza JJ, Silva DO, Gusmão MEN, et al. Association between unplanned pregnancy and the socioeconomic context of women in the area of family health. Acta Paul Enferm [Internet]. 2012 [cited 2016 Feb 15];25(3):415-22. Available from: http://dx.doi.org/10.1590/S0103-21002012000300015

7. Fiorin JL. Linguagem e ideologia**.** São Paulo: Ática; 2011.

8. Campos RTO, Ferrer AL, Gama CAPD, Campos GWDS, Trapé TL, Dantas DV. Avaliação da qualidade do acesso na atenção primária de uma grande cidade brasileira na perspectiva dos usuários. Saúde debate [Internet]. 2014 Out [cited 2016 Jan 23];38(esp):252-64. Available from: http://dx.doi.org/10.5935/0103-1104.2014S019

9. Oliveira LS, Almeida LGN, Oliveira MAS, Gil GB, Cunha ABO, Medina MG, et al. Acessibilidade a atenção básica em um distrito sanitário de Salvador.

Ciênc saúde coletiva [Internet]. 2012 Nov [cited 2016 Feb 11];17(11):3047-56. Available from: http://dx.doi.org/10.1590/S1413-81232012001100021

10. Fukuya N, Silva AEBC. Análise do sistema de regulação do município de Hidrolândia/GO. In: 63ª Reunião Anual da SBPC; 2011; Goiânia, Goiás. Anais... Goiânia: Universidade Federal de Goiás; 2011. p 1-4.

11. Brasil. Conselho Nacional de Secretários da Saúde. Atenção Primária e Promoção da Saúde: coleção para entender a gestão do SUS. Brasília; 2011. [cited 2016 Mar 3]. Available from: http://www.conass.org.br/biblioteca/atencao-primaria-e-promocao-da-saude/

12. Cecilio LCO, Andreazza R, Carapinheiro G, Araújo EC, Oliveira LA, Andrade MGG. A Atenção Básica à Saúde e a construção das redes temáticas de saúde: qual pode ser o seu papel? Ciênc saúde coletiva [Internet]. 2012 Nov [cited 2016 Feb 15];17(11):2893-902. Available from: http://dx.doi.org/10.1590/S1413-81232012001100006

13. Viegas SMF, Penna, CMM. Integrality: life principle and right to health. Invest educ enferm [Internet]. 2015 May/Aug [cited 2015 Nov 15];33(2):237-47. Available from: http://dx.doi.org/10.17533/udea.iee.v33n2a06

14. Bonfada D, Cavalcante JRLP, Araújo DP, Guimarães J. A integralidade da atenção à saúde como eixo da organização tecnológica nos serviços. Ciênc saúde coletiva [Internet]. 2012 Fev [cited 2015 Oct 23];17(2):555-60. Available from: http://dx.doi.org/10.1590/S1413-81232012000200028

15. Brito-Silva K, Bezerra AFB, Tanaka OY. Direito à saúde e integralidade: uma discussão sobre os desafios e caminhos para sua efetivação. Interface (Botucatu) [Internet]. 2012 Mar [cited 2016 Feb 20];16(40):249-60. Available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S1414-32832012000100019&lng=pt

16. Silva MM, Budó MDLD, Resta DG, Oliveira SS, Ebling SBD, Carvalho SORM. The entire family health: limits and possibilities in view of the team. Ciênc cuid saúde [Internet]. 2013 Jan/Mar [cited 2016 Feb 5];12(1):155-63. Available from: http://ojs.uem.br/ojs/index.php/CiencCuidSaude/article/view/21736/pdf_1

17. Ranji U, Kurani N, Salganicoff A, Jankiewicz A, Rousseau D. Preventive services for women and the affordable care act. JAMA [Internet]. 2014 May [cited 2016 Apr 3];311(18):1846. Available from: https://jamanetwork.com/journals/jama/fullarticle/1869217

Received: October 24, 2016

Approved: October 24, 2017

Published: April 16, 2018

The Revista Baiana de Enfermagem use the Creative Commons license – Attribuition -NonComercial 4.0 International.
https://creativecommons.org/licenses/by-nc/4.0/
This article is an Open Access distributed under the terms of the Creative Commons (CC BY-NC).
This license lets others remix, adapt and create upon your work to non-commercial use, and although new works must give its due credit and can not be for comercial purposes, the users do not have to license such derivative works under the same terms.