Rev Saúde Pública 2013;47(6):1-15

Review

DOI:10.1590/S0034-8910.2013047004581

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Humanization policy in primary health care: a systematic review

ABSTRACT

OBJECTIVE: To analyze humanization practices in primary health care in the Brazilian Unified Health System according to the principles of the National Humanization Policy.

METHODS: A systematic review of the literature was carried out, followed by a meta-synthesis, using the following databases: BDENF (nursing database), BDTD (Brazilian digital library of theses and dissertations), CINAHL (Cumulative Index to nursing and allied health literature), LILACS (Latin American and Caribbean health care sciences literature), MedLine (International health care sciences literature), PAHO (Pan-American Health Care Organization Library) and SciELO (Scientific Electronic Library Online). The following descriptors were used: Humanization; Humanizing Health Care; Reception: Humanized care: Humanization in health care; Bonding; Family Health Care Program; Primary Care; Public Health and *Sistema Único de Saúde* (the Brazilian public health care system). Research articles, case studies, reports of experiences, dissertations, theses and chapters of books written in Portuguese, English or Spanish, published between 2003 and 2011, were included in the analysis.

RESULTS: Among the 4,127 publications found on the topic, 40 studies were evaluated and included in the analysis, producing three main categories: the first referring to the infrastructure and organization of the primary care service, made clear the dissatisfaction with the physical structure and equipment of the services and with the flow of attendance, which can facilitate or make difficult the access. The second, referring to the health work process, showed issues about the insufficient number of professionals, fragmentation of the work processes, the professional profile and responsibility. The third category, referring to the relational technologies, indicated the reception, bonding, listening, respect and dialog with the service users.

CONCLUSIONS: Although many practices were cited as humanizing they do not produce changes in the health services because of the lack of more profound analysis of the work processes and ongoing education in the health care services.

DESCRIPTORS: Humanization of Assistance. Delivery of Health Care. Primary Health Care. Public Health. Unified Health System. Qualitative Research. Review.

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Received: 10/3/2012
Approved: 8/19/2013

Article available from: www.scielo.br/rsp

INTRODUCTION

The victories won by the Brazilian Unified Health System (SUS) challenge us to develop proposals for interventions that will encourage further improvement. In this approach to constructing the SUS, the National Humanization of Hospital Care Program (PNHAH) was created in 2000. In 2003, the Brazilian Ministry of Health developed a proposal to expand humanization in the SUS beyond the confines of the hospital, establishing the National Humanization of Health Care and Health Care Management Policy, also known as the National Humanization Policy (NHP) and/or HumanizaSUS.[a]

Faced with ethical, political, financial and organizational obstacles, it became necessary to discuss humanization, questioning the techno-care model and the quality of care.[15,32] Thus, the NHP aims to make itself effective in health care practices, together with SUS principles, forming a political commitment to bringing about effective transformations and creating new realities in health care.[5]

The NHP is based on three structuring principles: transversality, indicating the expansion of communication between subjects and services, aimed at making changes in the areas of power, changes in the boundaries of knowledge and in labor relations; the inseparability of care and management, stating that there is an inseparable relationship between modes of care and ways to manage and own the work; and the affirmation that the roles and autonomy of subjects and collectives, understood as subjects in producing the services, for themselves and for the world, developing attitudes of co-responsibility in producing health care.[a]

The fulfillment of these structural principles depends on primary care that is the gateway to the system and organizes the network of services. Humanization permeates the work processes and those involved in primary care. In order for this to happen, various devices need to be used in producing health care, such as humanization working groups, an ombudsman, classification of the reception, among others.[a] Implementing these schemes calls for commitment on the part of all involved in the process of producing health.

Currently, there is a large number of publications on humanization in health care, especially qualitative studies, producing a significant accumulation of knowledge in this area and indicating the need for a meta-synthesis of this topic in primary care.[6] This study aimed to analyze humanization practices in the Brazilian health care system, based on the principles of the national humanization policy in Brazil.

METHODS

This is a qualitative, exploratory study, with a meta-synthesis design, that can be considered an interpretative integration of qualitative results that constitute an interpretative synthesis of the data, including phenomenology, ethnography and grounded theory, as well as other coherent and integrated descriptions or explanations of specific phenomena or events, characteristic of qualitative research.[36] This integration should go beyond the sum of its parts, as it offers a new interpretation of the results.[24]

The guiding question of this study was: What are the humanization practices of primary health care professionals, managers and users? To answer this question, an exhaustive bibliographic search was conducted in the following databases: BDENF (nursing database), BDTD (Brazilian library of thesis and dissertations), CINAHL (Cumulative Index to nursing and allied health literature), LILACS (Latin American and Caribbean Health Sciences Literature), MedLine (International Health Science Literature), PAHO (Pan-American Health Organization Library) and SciELO (Scientific Electronic Library Online). The books' texts were sought in catalogues of the main public health editors: Abrasco, Hucitec, Minstry of Health and Fiocruz.

The following descriptors of the topic were selected: Humanization; Humanization of Health Care; Reception; Humanized Care; Humanization in Health Care: Bond; Family Health Care Program; Primary Care; Public Health and Brazilian Unified Health System – *Sistema Único de Saúde*. These terms were sought in other languages. The Boolean operators (AND, OR, NOT) were used where necessary. Diverse strategies were used, inserting and/or withdrawing words, trying different combinations to find the highest number of studies. These criteria were used to search the book texts. To select studies, the following inclusion criteria were adopted: research articles, case studies, reports of experience, dissertations, theses and texts, published in English, Spanish or Portuguese, referring to qualitative empirical research on humanization practices in primary care, in the 2003 to 2011 period. Official Brazilian Ministry of Health documents were not included, nor were studies with the central objective of humanization in other areas, not primary health care.

The studies were collected and analyzed between July 2011 and January 2012. The data were collected separately by two researchers. All of the selected publications were read in their entirety, and their principal characteristics were synthesized.

[a] Ministério da Saúde. Secretaria de Atenção à Saúde. Humaniza SUS: documento base para gestores e trabalhadores do SUS. Brasília (DF); 2008.

The critical evaluation of the studies was based on the standardized Critical Appraisal Checklist For Interpretive & Critical Research (JBI-QARI) form,[b] which consists of a checklist of directives for evaluating the quality of qualitative research. This form is composed of ten questions, which investigate the agreement between: the study's methodology and its objectives, the method of data collection and analysis, methodology and interpretation of data, whether the participants' "statements" are presented appropriately, whether the ethical precepts of the research were followed and reported, among others. Thus, three response options were assigned to each study: yes, no and more information needed. The studies that obtained six or more affirmative responses in the JBI-QARI were kept in the final sample.

RESULTS

Initials, 4,127 publications on the subject were identified, of which 40 were selected to be included in the sample, 32 articles, 2 thesis, four dissertations and two chapters from books (Table 1 and 2). The flowchart of the inclusion and exclusion process can be seen in the Figure.

As regards the evaluation criteria applied to the included studies, seven studies obtained a score of seven,[2,11,16,30,33,39,41] 11 scored eight,[1,4,18,19,21,23,25,29,40,47,c] and 22 studies scored nine.[6,12-14,17,20,22,26,34,35,37,38,42,44-46,d,e,f,g,h,i] The meta-synthesis was mainly composed of studies carried out with health care professionals;[11,16,17,19,20,22,25,34,37,39,41,44,46,47,c,e,g,h] users;[13,14,23,33,35,41] or both.[2,4,13,18,29,30,38] To a lesser extent, health care unit workers, users and managers were surveyed.[6,46,f,g] Only one study[21] looked at managers and professionals;[19] students and professionals;[d] and students, professionals and users.[1]

As regards the regions in which the studies were conducted, the majority were concentrated in the Northeast,[1,4,18,34,40,45,h,i] Southeast[11,14,17,19-21,25,26,41,44,c,g,I] and South.[4,6,22,23,30,33,35,37-39,e] Only one study was conducted in the Midwest.[d]

As for the procedures; the studies used semi-structured interviews;[6,14,20,25,29,41,g] questionnaires;[4,18,37,41,d] focus groups;[22,42,c] workshops[40] and group discussions.[19] The use of combined methods was also noted: interviews and documental sources,[38] interviews and participative observation,[1,17,26,34,35,44,e] questionnaire and focus groups.[45-47]

The majority of analyses used were content analysis,[5,12,16,20,26,30,35,44,45,47,g] followed by thematic analysis.[4,6,18,37,42] Other strategies such as descriptive analysis,[41] discourse analysis,[22,29] dialectical hermeneutics and ethnography[25,40] were used to a lesser extent.

The content analysis technique proposed by Bardin[3] (2008) was used to achieve the constructed taxonomies. It consists of three stages: pre-analysis, categorized by the organization of the material; exploration of the material, in which the material analyzed is codified; and dealing with the results, inference and interpretation, in which the data are categorized, with the recording units grouped according to characteristics in common.

The taxonomies constructed were categorized into three main domains: organization and infrastructure of primary health care services; work processes; and technology of relations. Constant objective comparisons were performed aiming to identify similarities and differences between the phenomena in question.

Organization and infrastructure of primary health care services

In this domain, organizational aspects and those primary health care of infrastructure are presented. This taxonomy is based on aspects such as facilities, access to services, lack of medication and equipment.

The precariousness of facilities in health care centers was a recurrent theme in several studies.[6,23,25,37,46,47] There were problems related to size and availability of consulting rooms, uncomfortable or insufficient chairs, poor ventilation and problems in structural maintenance.[21,f]

Some studies[21,35] reported services operating in very small physical areas, without even a waiting room.

[b] Joanna Briggs Institute. Joanna Briggs Institute Reviewers' Manual. Adelaide; 2011 [cited 15 Jun 2012]. Available from: http://joannabriggs.org/assets/docs/sumari/ReviewersManual-2011.pdf

[c] Silva KA, Fernandes ND, Xavier MCS. Caminhos do acolhimento: relato de experiência em uma Unidade de Saúde da Família no município do Rio de Janeiro. In: Pinheiro R, Mattos RA, organizadores. Ateliês do Cuidado - VII seminário do Projeto integralidade: saberes e práticas no cotidiano das instituições de saúde. Rio de Janeiro: Abrasco, 2008 p.356.

[d] Soares LFP. Inovação e Resistência na Implantação do processo de humanização na Secretaria Municipal de Goiânia, sob as lentes da Bioética [dissertação de mestrado]. Goiânia: Universidade Católica de Goiás; 2005.

[e] Urbano GB. Integralidade na prática assistencial da equipe de enfermagem: a relação da escuta na interação usuário e profissional no município de Paranavaí-PR [dissertação de mestrado]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2009.

[f] Vilar RLA. A política de humanização e a Estratégia de Saúde da Família: Visões e Vivências [tese de doutorado]. Natal: Universidade Federal do Rio Grande do Norte; 2009.

[g] Villar RMT. Humanização das condições de trabalho um dos pré-requisitos para a humanização da assistência? [dissertação de mestrado]. Rio de Janeiro: Fundação Osvaldo Cruz; 2009.

[h] Rodrigues MP. A representação social do cuidado no Programa Saúde da Família na cidade do Natal [tese de doutorado]. Natal: Universidade Federal do Rio Grande do Norte; 2007.

[i] Campos LVO. A Estratégia de Saúde da Família em sua micropolítica: um estudo de caso sobre a Humanização nos processos de trabalho [dissertação de mestrado]. São Paulo: Universidade de São Paulo; 2011.

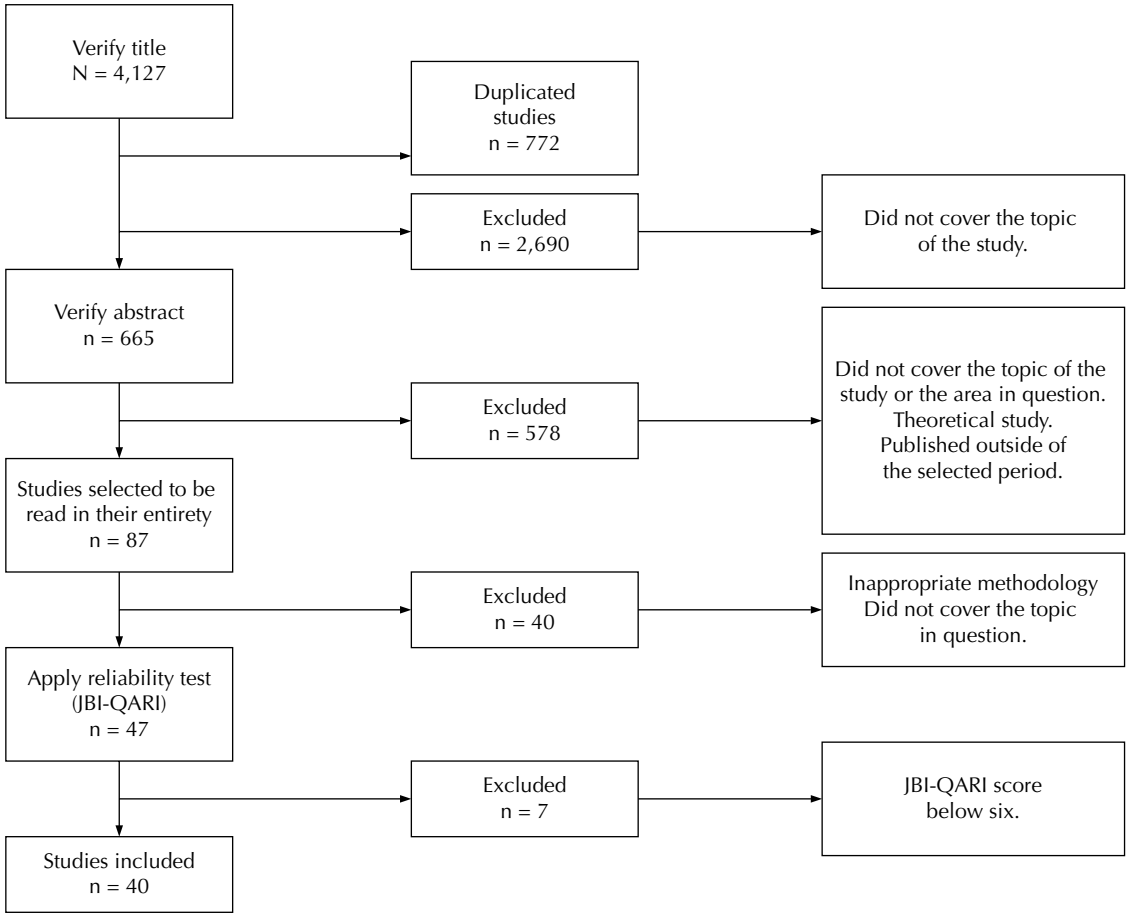

Figure. Flow chart of the selection process of studies for the meta-synthesis. Sao Paulo, SP, Southeastern Brazil, 2012.

There were studies[21,23] which showed user dissatisfaction with the physical space, deeming it too small to meet demand and making waiting to be seen an uncomfortable experience.

The meta-synthesis indicated environmental problems interfering with work processes, compromising the quality of service provided, demotivating health care professionals and managers and discomfiting users [4,20,25,40,47,f] Lack of adequate physical space in the units lead to a lack of privacy in conversations with the users.[17,20,21]

Insufficient equipment and material resources in the units interfered with continuity of care and produced poor working conditions.[25,42,f,g,h] One study[f] highlighted a lack of effective maintenance and conservation of equipment in health care units.

A recurring theme in the meta-synthesis concerned the lack of signs identifying different sections of the units.[13,18]

Regarding access to health care services, the majority of studies indicated that it took place through making appointments for some types of scheduled groups, such as hypertensives, diabetics and pregnant women, among other at risk groups. For spontaneous demand, appointments were provided on a day to day basis.[41,46,f]

It was noted that the teams had difficulties managing problems in seeing all patients, observed in the queues for appointments, arguments in the distribution of a reduced number of appointments and full doctor's agendas.[22,23,34,42,47] Dissatisfaction with waiting times and queues was related to a dehumanizing situation.[18,23,35,38,46] Thus, the studies described difficulties in accessing health care services due to high, predominantly spontaneous, demand, leading to suffering on the part of health care professionals and service users.[23,25,34,40,42,44]

One obstacle to humanized care, indicated by the research, concerned the lack of an effective referral and counter-referral system to other levels of care,[12,21,25,47] especially with regards to tests and/or consultations with specialists.[38,41,42,46,h] The study carried out by Lima et al,[23] in which users were shown to be satisfied with appointments made for tests and with the referral and counter-referral system that included referrals to specialists and to surgery.

Table 1. Description of characteristics of the articles constituting the meta-synthesis. Sao Paulo, SP, Southeastern Brazil, 2012.

Year	Journal	Vol./N	Title	Authors	Place	Objective	Type of study
2003	O Mundo da Saúde	v.27, n.2	*Humanização no Programa de Saúde da Família* (Humanization of the Family Health Care Program)	Chaves EC, Martines WRV	Family health Care Program, Sao Paulo, SP	Understand how FHCP employees view humanization of the FHCP and what their mission would be when they speak of Humanization.	Research
2003	Cadernos de Saúde Pública	v.19, n.1	*Acesso e acolhimento aos usuários em uma unidade de saúde de Porto Alegre, Rio Grande do Sul, Brasil* (User access and reception in a health care unit in Porto Alegre, RS)	Ramos DD, Lima MADS	Health care unit in Porto Alegre, RS	Characterize, from the point of view of the users, access to health care and how services are provided, with regards the way they are received, in a health care unit in Porto Alegre, RS.	Research
2004	Cadernos de Saúde Pública	v.20, n.6	*Acolhimento e vínculo em uma equipe do Programa de Saúde da Família* (Reception and bonding in a Family health Care Program team)	Schimith MD, Lima MADS	A municipality in the Fourth Regional health care Department, RS	To analyze FHCP work with regards the reception of users and bonding during their work, aiming to characterize the mode of producing health care, as well as workers' perception of service users.	Research
2004	Cogitare Enfermagem	v.9, n.1	*Acolhimento no programa saúde da família: um caminho para a humanização da Atenção à Saúde* (Reception in the family health care program: a path to humanizing Health Care)	Silveira MFA, Felix LG, Araújo DVd, Silva IC	FHCP, Campina Grande, PB	To identify the professionals' views of the FHCP reception; to describe how they practice receiving users, showing favorable and unfavorable conditions in consolidating a culture of humanization within the FHCP.	Research
2004	Saúde e Sociedade	v.13, n.3	*O cuidado, os modos de ser (do) humano e as práticas de saúde* (Care, human behavior and health care practices)	Ayres JRCM	Primary Health Care Units	To examine philosophical and practical challenges in humanization in health care practices.	Report
2004	Revista Escola de Enfermagem da USP	v.38, n.2	*Descrição e análise do acolhimento: uma contribuição para o Programa de Saúde da Família* (Description and analysis of reception: contribution to the Family Health Care Program)	Fracolli LA, Zoboli ELCP	Family health Care Unit in Sao Paulo, SP	To identify the processes of "reception" in Family Health Care Units in Sao Paulo, SP.	Research
2006	Pediatria (São Paulo)	v.28, n.4	*Humanização e autogestão em uma unidade básica de saúde* (Humanization and self-management in a primary health care unit)	Silveira MGG, Baldacci ER	Primary Health Care Unit on the outskirts of the city of Sao Paulo, SP	To describe the self-management process developed within a primary health care unit and contribute to similar initiatives in other disadvantaged locations in the country.	Research

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2006	Revista Espaço para a Saúde, Londrina	v.8, n.2	*A implantação do acolhimento no processo de trabalho de equipes de saúde da família* (Establishing receiving users in the work process of a family health care team)	Scholze AS et al	FHCP unit in Barra do Rio, Balneário Camboriú, SC	To describe the implementation of receiving users as a way of organizing work in health care in the FHCP.	Report
2007	Acta Paulista de Enfermagem	v.20, n.1	*Acesso e acolhimento em unidades de saúde na visão dos usuários* (Access and reception in health care units, from users point of view)	Lima MADS, et al	Two health care units in Porto Alegre, RS	To characterize, according to users' opinions, how health care access is conformed and how health care is provided to them, with regards how they are received in health care units in Porto Alegre, RS.	Research
2007	Cadernos de Saúde Pública	v.23, n.2	*Acolhimento e transformações no processo de trabalho de enfermagem em unidade básica de saúde de Campinas, São Paulo, Brasil* (Reception and transformations in the work process in nursing in a primary care unit in Campinas, São Paulo, SP)	Takemoto MLS, Silva EM	Five health care centers in Campinas, SP	To report transformations in nursing work with the incorporation of reception into the process of establishing the Paideia health care project in Campinas, from 2001.	Research
2007	Revista APS	v.10, n.2	*Acolhimento: uma experiência em pesquisa-ação na mudança do processo de trabalho em saúde*	Andrade CS, Franco TB, Ferreira VSC	Family Health Care Strategy Jacinto Cabral de Itabuna, BA	To portray the development of research-action about reception and accessibility for service users in a Family Health Care Unit in Itabuna, BA.	Research
2008	Cadernos de Saúde Pública	v.24, supl. I	*Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais da saúde* (Access and reception in primary health care: an analysis of health care user and professional perception)	Souza ECF, et al	Family Health Care Primary Care Unit in three state capitals in the Northeast, two cities and a medium sized town	To evaluate the potential and the challenges to comprehensive care in Primary health Care, according to health care user and professional perception, with the work process developed in the primary health care units in the state capitals in the northeast as a reference.	Research
2008	Revista da Rede de Enfermagem do Nordeste	v.9, n.4	*Assistência de saúde humanizada: Conquistas e desafios em Campina Grande, PB* (Humanized health care: Victories and challenges in Campina Grande, PB)	França ISX, Marinho DDT, Baptista RS	Primary health care units, Campinas Grande, PB	To identify victories and challenges in the humanization process in primary health care units in Campina Grande, PB.	Research

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2008	Arquivos Catarinenses de Medicina	v.37,n.4	*Implantação do acolhimento em uma unidade local de saúde de Florianópolis* (Establishing reception in a health care center in Florianópolis, SC)	Nascimento PTA, Tesser CD, Neto PP	Local health care units in Florianópolis, SC	To describe the establishment of reception as a form of organizing work in health in the family health care program.	Case study
2008	Revista Mineira de Enfermagem	v.12, n.2	*O acolhimento sob a ótica de profissionais da equipe de saúde da família* (Reception from the point of view of health care professionals in a family health care strategy team)	Freire LAM, et al	Family Health Care Program, Belo Horizonte, MG	To report the perception that FHCP professionals have of receiving users and to encourage reflection on reception practices in this unit.	Research
2008	Physis: Revista de Saúde Coletiva	v.19, n.4	*Os processos de formação na política Nacional de Humanização: a experiência de um curso para gestores e trabalhadores da atenção básica em saúde* (Formation processes in the National Humanization Policy: the experience of a course for managers and workers of primary health care)	Guedes CR, Pitombo LB, Barros MEB	Municipality in Rio de Janeiro	Report the experience of a National Humanization Policy training course focused on primary care managers and workers in municipality in the state of Rio de Janeiro, RJ.	Reports
2009	Interface: Comunicação, Saúde, Educação.	v.13, supl. I.	*Gestão participativa e corresponsabilidade em saúde: limites e possibilidades no âmbito da Estratégia de Saúde da Família* (Participatory management and responsibility in health: limits and possibilities within the Family Health Care Strategy)	Trad LAB, Esperidião MA	Six municipalities in Bahia, Sergipe and Ceará	To discuss the limits and possibilities of incorporating participatory management and incorporation of the principle of responsibility within the Family Health Care Strategy (FHCS).	Research
2009	Ciência e Saúde Coletiva	v.14, supl. I	*Tecnologia das relações como dispositivo do atendimento humanizado na atenção básica à saúde na perspectiva do acesso, do acolhimento e do vínculo* (Technology of relations as humanized care tools in primary health care from the perspective of access, reception and bonding)	Coelho MO, Jorge MSB	Fortaleza, CE	To discuss how users and workers perceive access, reception and bonding as light technologies in primary care in Fortaleza, CE.	Research
2009	Revista Gaúcha de Enfermagem	v.30 n.1	*Humanização da assistência de enfermagem: percepção de enfermeiros nos serviços de saúde de um município* (Humanization of nursing: perceptions of nurses in health care services in a municipality)	Beck CLC, et al	32 primary health care units in a municipality in the center of the state of RS	To identify the perception of nurses regarding the humanization of health care services in a municipality and point out users and nurses' difficulties in performing humanized care.	Research

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2009	Revista da Escola de Enfermagem USP.	v.43, n.2	*Formação do vínculo na implantação do Programa de Saúde da Família numa Unidade Básica de Saúde* (Bonding in implementing the Family Health Care Program in a Primary Care Unit)	Monteiro MM, Figueiredo VP, Machado MFAS	Primary health care units in Fortaleza, CE	To understand bonding strategies between health care users and professionals in the Family Health Care Program (FHCP) in a primary health care unit in Fortaleza, CE.	Research
2009	Revista Baiana	v.33, n.3	*O acesso por meio do acolhimento na Atenção Básica* (Access through reception in Primary Care)	Coelho MO, Jorge MSB, Araújo ME	PHCU of the Municipal Department of Health, Fortaleza, CE	To discuss how users perceive access to primary health care units through their reception.	Research
2009	Revista Gaúcha de Enfermagem	v.30, n.4	*Representações sociais da relação auxiliar de enfermagem usuário no contexto do Programa Saúde da Família* (Social representations of the auxiliary nurse-patient relationship in the context of the Family Health Care Program)	Eulálio MC, Santos ERF, Albuquerque TP	FHCP units in the city of Campina Grande, PB	To understand the auxiliary nurse-patient relationship through social representations of contact, constructed by these health care professionals in the context of the FHCP.	Research
2009	Revista Latino-Americana de Enfermagem	v.17,n.6	*Preparando a relação de atendimento: ferramenta para o acolhimento em unidades de saúde* (Preparing the service relationship: tool for receiving users in health facilities)	Matumoto S, et al	Health care unit in a municipality in the state of Sao Paulo	To identify and analyze aspects of preparing for the worker/ user relationship established in a primary health care unit in a municipality in the state of São Paulo, from the perspective of receiving users.	Research
2009	Revista APS	v.12, n.4	*A arte de acolher através da visita da alegria* (The art of receiving users through happy visits)	Pekelman R, et al	Jardim Itu health care unit community health care service/ Conceição hospital Group, Porto Alegre, RS	To promote health through laughter, from the perspective pf humanizing care and promoting health, essential to the role of primary health care services.	Reports
2010	Physis Revista de Saúde Coletiva.	v.20, n. 4	*Sentidos e Práticas da Humanização na Estratégia de Saúde da Família: a visão de usuários em seis municípios do Nordeste* (Meaning and practice of humanization in the Family Health Care Strategy: views of users in six municipalities in the Northeast)	Trad LAB, Esperidião MA	Small and large municipalities in Bahia, Sergipe and Ceará	To investigate to what extent the principles of humanization are appropriated and translated in the context of Family Health Care Program units and teams.	Research

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2010	Saúde e Sociedade	v.19, n.3	*A visita domiciliar na ESF: conhecendo as percepções dos familiares* (Home visits in the FHCS: discovering the families' perceptions)	Cruz MM, Bourget MMM	East zone of the municipality of Sao Paulo, SP	To understand the meaning attributed by family members to home visit by Family Health Care Strategy (FHCS), aiming to recognize the difficulties and the potential of this practice.	Research
2010	Revista Latino-Americana de Enfermagem	v.18, n.4	*A humanização do cuidado na ótica das equipes da Estratégia de Saúde da Família de um município do interior paulista, Brasil* (Humanization of care from the point of view of Family Health Care Strategy teams in a municipality in the interior of São Paulo state)	Marin MJS, Storniolo LV, Moravcik MY	Municipality in the interior of Sao Paulo, SP	To analyze understanding of humanization of care, from the point of view of professionals in Family Health Care Strategy teams.	Research
2010	Ciência e Saúde Coletiva	v. 15, supl.3	*Acolhimento na Atenção Básica: reflexões éticas sobre a Atenção à Saúde dos usuários* (Reception in Primary Care: ethical reflections on health care)	Brehmer LCF, Verdi M	5 Primary health Care Units in a municipal health care network in a large municipality in Santa Catarina	To identify and analyze ethical implications of day-to-day reception practices in Primary Health Care Units and users' reflections on SUS health care.	Research
2010	Revista Nursing	v,12, n.144	*O acolhimento no cotidiano da saúde: um desafio para a enfermagem* (Reception in day-to-day health care: a nursing challenge)	Santos EV, Soares NV	Primary Health Care Unit in a municipality in Rio Grande do Sul	To investigate, together with nurses practicing in Primary care of a municipality in Rio Grande do Sul, knowledge of the SUS National Humanization Policy, focusing on receiving users.	Research
2011	Ciência e Saúde Coletiva	v.16, n.3.	*Condições e processo de trabalho no cotidiano do Programa Saúde da Família: coerência com princípios da humanização em saúde* (Working conditions and processes in the day-to-day operations of the Family Health Care Program: coherence with principles of humanizing health care)	Trad LAB, Rocha AARM	3 states in the Northeast: Bahia, Sergipe and Ceará	To analyze humanization in work, in the context of the Family Health Care Program.	Research
2011	Interface: Comunicação, Saúde, Educação.	v.15, n.36	*A contribuição do acolhimento e do vínculo na humanização da prática do cirurgião-dentista no Programa Saúde da Família* (The contribution of reception and bonding in humanizing dental surgeon practice in the Family Health Care Program)	Pinheiro PM, Oliveira LC	FHCP Fortaleza, CE	To understand how light technologies are used in receiving and bonding with users in dental practice, in the Family Health Care Program, Fortaleza, Ceará, in the sense of constructing humanized care.	Research
2011	Interface: Comunicação, Saúde, Educação.	v.15, n.38	A visão de moral dos profissionais de uma unidade básica de saúde e a humanização (Moral vision of health care professionals in primary health care units and humanization)	Junges et al	Primary health care unit in Vila Campina, Sao Leopoldo, RS	To analyze the moral vision of health care professionals in a primary health care unit (PHCU) and highlight implications for humanizing health care.	Research

Table 2. Characteristics of texts of dissertations, theses and books that comprised the meta-synthesis. Sao Paulo, SP, Southeastern Brazil, 2012.

Year	Place	Title	Authors	Place	Objective	Type of study
2007	BDTD – Postgraduate Program in Health Care Sciences. *Universidade Federal do Rio Grande do Norte*	*A representação social do cuidado no Programa de Saúde da família na cidade de Natal* (The social representation of care in the Family Health Care Program in Natal)	Rodrigues MP	Family Health Care Program in Natal, RN	Understand the social representations of care of FHCP teams in Natal and how these representations guide the daily actions of these individuals during the work process.	Research
2009	BDTD - Postgraduate Program in Social Sciences. *Universidade Federal do Rio Grande do Norte*	*A política de humanização e a Estratégia de Saúde da Família: Visões e vivências* (A politics of humanization and the Family Health Care Strategy: Views and Experiences)	Vilar RLA	Family Health Care Strategy, Natal, RN	To reflect on the guiding theoretical and organizational frameworks of NHP and its echoes in municipal health policy in Natal; for analyzing milestones in local politics, discovering the views and experiences of humanizing agents in the day-to-day work processes and for the main challenges of the Humanization policy.	Research
2005	BDTD - Postgraduate Program in Health Care and Environmental Sciences - *Universidade Católica de Goiás*	*Inovação e resistência na implantação do Processo de humanização na secretaria Municipal de saúde do município de Goiânia-GO, Sob as lentes da bioética* (Innovation and resistance in implementing the humanization process in the municipal health department of Goiânia-GO, From a bio-ethical point of view)	Soares LFP	10 health care units in municipal health department of Goiânia	A bioethical focus on the public health care system professional involved in the process of humanizing health care as envisaged by the Ministry of Health, as well as their activity as a protagonist in this process.	Research
2009	BDTD - Postgraduate Program in Children and women's health. *Fundação Oswaldo Cruz*	*Humanização das condições de trabalho: Um dos pré-requisitos para a humanização da assistência (*Humanization of working conditions: One of the pre-requisites for humanizing health care)	Villar RMT.	Health care center and in a policlinic, both part of the municipal health department, Rio de Janeiro	To analyze the meaning health care professionals attribute to the interference of working conditions in humanizing health care provided to service users.	Research
2009	BDTD - *Universidade do Estado do Rio de Janeiro*. Institute of Social medicine.	*Integralidade na prática assistencial da equipe de enfermagem: a relação da escuta na interação usuário e profissional no município de Paranavaí, PR* (Comprehensiveness in the care practices of a nursing team: listening in user-professional interaction in Paranavaí, PR)	Urbano GB	Two primary health care units in Paranavaí, PR	To observe the activities of the nursing team in Primary Care, seeking to characterize interactions with the users and prioritizing listening as a requisite of integrality.	Research
2011	BDTD - *Universidade de São Paulo* – Nursing School, Ribeirão Preto	*A Estratégia de Saúde da Família em sua micropolítica: um estudo de caso sobre a humanização nos processos de trabalho* (Family Health Care Strategy in micro-policies: a case study of humanization in work processes)	Campos LVO	Family Health Care Strategy in Ribeirao Preto, SP	To map the ways of producing and capturing humanization activities which constitute micro-policies in the work processes of a FHCS team.	Research
2007	–	*Acolhimento e os processos de trabalho em saúde: o caso de Betim, MG* (Reception and work processes in health care: the case of Betim, MG)	Franco TB, Bueno WS, Merhy EE	Primary health care unit Rosa Capuche, in Betim, MG	To assess the impact of access mechanisms and explore the possibilities of new designs of day-to-day micro-policies in certain health care models.	Reports
2008	–	*Caminhos do acolhimento: relato de experiência em uma Unidade de Saúde da Família no município do Rio de Janeiro* (Paths the receiving users: reports of experience in a family health care unit in Rio de Janeiro)	Silva KA, Fernandes ND, Xavier MCS	Family health care unit in Rio de Janeiro	To discuss the experience of establishing reception of users in a family health care unit in Rio de Janeiro.	Reports

BDTD: Brazilian Digital Library of theses and dissertations

Some studies recorded difficulties in obtaining prescribed medications, as well as a lack of medication in the primary health care pharmacy.[23,38,42,f]

Faced with these concerns, in this domain the predominance of unsatisfactory aspects stands out, with two subcategories emerging: the first concerning physical infrastructure and materials, frequently observed in the studies, and the second showing flows in the provision of care which facilitate, or make more difficult, access to health care services.

Work processes

In this dimension, elements of the organization of the work process are shown. Issues relate to an insufficient number of health care professionals, work overload, poor remuneration,[21,g] fragmentation of work processes, team work, professional profile and responsibilities.

The studies indicated with there was an insufficient number of health care professionals in the health care teams, making access to services and receiving users more difficult.[25,29,30,35,40,43,f] Thus, with a significant demand for care, work overload occurs which, according to some studies, can compromise the agenda of group, intra-team and user centered activities.[1,34,43,f]

In the meta-synthesis, it was perceived that the practice developed in the health care services is permeated by fragmentation of the work processes, perpetuating a care model centered on curative care and focused on the complaint.[47,e,f,i]

Some studies[21,g] reported that poor remuneration of health care professionals has been highlighted as a difficulty in providing quality health care. Thus, health care professionals feel obliged to work in other services to complement their income.

Another recurrent theme concerns constructing interdisciplinary practices, based on team work, with defined roles and attributes for each health care professional.[11,47] Some studies mentioned that the health care professionals needed to place themselves on a level with service users, avoiding hierarchical relationships, valuing integrative practice and popular wisdom.[45,f] Educational activities carried out within the services contribute to the individual becoming autonomous and qualifying their way of life.[33,38,g] Few examples of collective discussions between professionals were observed. Studies indicated that team meetings did not take place regularly, either weekly, fortnightly or monthly.[47,f] In one case, there were no team meetings.[22]

The meta-synthesis showed that the teams took responsibility for the users' needs, from arrival to departure, responding and referring appropriately, aiming to solve problems within their capacity and with the resources available in the unit and the health care network.[2,23,26,44] However, as one study indicated, the process of taking responsibility within the scope of health care and management is fairly incipient in primary care.[45]

A recurring topic was the pack of a professional profile, identified as an element which made humanized care difficult. Concerning the lack of health care professionals prepared to act in a humanized way, studies considered that investment in ongoing professional development and education is necessary.[18,25,29,41,c,f,g,h] However, a new profile of professional was identified, more sensitive to the real needs of the population, producing health care capable of generating social satisfaction and technical excellence in resolving problems for users and for society.[40] The professionals needed to be sensitive and to take responsibility for primary health care, using new practices based on humanization both in health care and in citizenship.

The difficulties reported in this dimension have negative repercussions on different aspects of the work process developed by teams committed to planning, organizing and carrying out activities in primary care, and reflecting negatively on the quality of service provided.

Technologies of relations

In this domain, the following technologies of relations, called light technologies by Merhy,[28] are apparent, these being: reception, bonding, listening, respect and dialogue.

The meta-synthesis identified reception as an essential light technology in health care service practice, contributing to changes in the care model, which is no longer centered on the disease but on the subject.[6,34,f] The majority of studies indicated that the reception of users is something that all health care team members can do in all day-to-day situations presenting the possibility of listening to them.[17,20,38,39,c,e]

Studies[1,f] have shown that the reception of users was identified as a tool in reorganizing the work process, basing the relationships between professionals and service users on qualified listening, taking responsibility, commitment to problems solving and multi-professional work. From another perspective, receiving users is based on the clinical-biomedical model, with health care based on the complaint-behavior model and as a form of triage.[17]

The meta-synthesis indicated that the reception proposed in the studies is based on a dialogue-reception.[6,22] Thus, communication is shown to be an important element in the humanization of health care, making the professional's openness to qualified listening essential.[14,17,20,41,e,f]

As with the reception, bonding is another light technology associated with humanization which is commonly

found in publications, in which it is observed that bonding cannot take place without the users being recognized as subjects.[29,e] Bonding with health care service users increases the efficacy of health care actions and encourages user-participation in their own care.[38]

From this perspective, an activity which recurs in the studies is that of home visits from community health workers, considered an important means of bringing the health care professional closer to the daily life of the user, encouraging friendly relationships and trust based on bonding.[14,33,34,46,f]

During the meta-synthesis, some basic human characteristics were identified, such as listening, paying attention, becoming involved, contact and sharing, which cannot be replaced by hard technologies, as there are essential elements in good professional/user relationships.[16]

Light technologies are recurring issues in the synthesized studies. These technologies are useful tools in radically changing work processes, especially if the professionals are willing to make use of all the technologies in their "bag of tricks",[28] aiming to listen to and resolve the users' health care needs.

DISCUSSION

The studies included in the meta-synthesis were Brazilian publications, indicating the invisibility, on an international level, of humanization practices developed in this country. In the publications, it can be perceived that there is currently ample debate on the concepts and practices of humanization, showing the need for the affirmation of this discourse within Brazilian health care services.

The dimensions found in the meta-synthesis are concerned with the principles proposed by the NHP, these being: health care inseparable from management, people playing their roles, taking responsibility and the autonomy of subjects and collectives.[a] Transversality refers to the increased degree of communication between subjects and collectives[11] and is mainly concerned with the dimension which covers the work process. Health care inseparable from management indicates the inseparability between the clinical side and the political side and between producing health care and subjectivity,[a] connecting the organization and infrastructure of primary health care services. The third principle of fulfilling roles, co-responsibility and autonomy of subjects and collective, is connected with technology of relations, as it deals with these issues and talks of subjects who take a central place in health care events.[a]

Of the humanization practices present in the meta-synthesis, there was no mention of the notion of humanization as a reference to "human good"[5] meaning an attitude that should be prescribed and imposed on others, but rather concrete social and professional practice which affect and modify ways of acting and caring.[5]

The NHP seeks to value day-to-day health care services, the work process being a fundamental piece in the effectiveness of this policy. This policy does not depend on norms, protocols or bureaucratic apparatus, but on the performance of different subjects involved in producing health care. Thus, the way of changing health care cannot be changed without changing the organization of work processes.[5]

For all the subjects who collectively seek a humanized health care system, the pattern of health care organization and work management needs to advance,[32] often being vertical and hierarchized discourses, making communication difficult.

To develop new logics of work, based on processes in the act (work micropolicies),[10] it is essential to discuss the work process, and activate discussion within the work process, creating tools that aid collectives in permanent assessment of the work processes. In this case, ongoing education in health care can be seen as a fundamental tool in work based learning.

According to Ceccim,[9] work process discussion groups enable bonding, taking responsibility and participation of managers and workers to be strengthened, encouraging a healthy work environment, creating active participative networks in health care services.

Another way of widening humanization practices consists in effective participation in managing work processes, including subjects in health care decision making. The NHP includes shared management as a directive to be followed to include new subjects and multiply the agents of this policy.[a]

According to Campos[7] (2005), humanization in the SUS requires the shared management system to be further improved. Including subjects needs to occur in an ethical-aesthetic-political way, starting from the differences and estrangements that the subjects produce, aiming for a practice that seeks the common good.[a]

In the meta-synthesis, gaps were observed concerning user participation in humanization practices in primary care. The texts include issues related to user satisfaction and access to health care services, and how this affects humanization. Humanization, in the sense of social participation and taking responsibility, was not observed in the meta-synthesis.

Social control, exercised in institutional participation spaces, is considered to be an important tool in creating collective subjects. Citizens' participation in health care provides for the inclusion of new subjects, above all users, making the health care system and services

co-managed and creating spaces to construct processes of taking responsibility with health care policies.[31]

A humanization policy is expected to strengthen issues of health care participation and users' rights as a priority in the services, increasing different subjects' inclusion and responsibility.[31] In this process of including all subjects in health care, it is vital to think of proposals for the SUS that lead to considering macro- and micro-policies. The former includes examples of SUS management and the latter power relationships constructed between users, workers and managers.[11]

Negative aspects of health care recurred in the meta-synthesis: the precariousness of health care received, discontinuity in care and lack of guaranteed longitudinal care across different levels.[27] When a care network is fragmented, primary care cannot play its central role in communication and coordinating care.

One of the challenges that makes humanizing health care difficult is the lack of financial resources for improving the physical and material structure of the services. However, such an improvement does not depend solely on physical and material structure, as it is essential to value experiences from day-to-day health care work, which have the power to transform and reinvent services and practices.[32]

In this meta-synthesis, there were many practices called "humanizing", but they lost their force to produce significant changes in the health care services as they were developed as isolated actions that did not analyze work processes. The NHP was a strategy which appeared to be an ally in broadening and affirmation within the SUS.[37] It stood out that users, workers and managers took co-responsibility for the organization and functioning of health care services through participation and social control. Only with shared knowledge, commitment and responsibilities will it be possible to establish new practices which invite the ethical-political re-thinking of day-to-day health care services.

To conclude, the meta-synthesis indicated that humanization aims to supplant the hegemonic biomedical model, moving towards users' centrality, which is the subject of the care process. Therefore, technologies of relations work as tools in bonding and in health care practices which exceed the fragmented vision of care.

The greatest challenge faced by the NHP is to organize care networks and health care production with shared management, which guarantees user access with quality and problem solving. The services should be areas of sociability, with ongoing education connected to work processes, in which the production of health care is understood as producing subjectivity.

To improve the effectiveness of humanization in primary care, it is essential to invest in implementing the following tools proposed by the NHP: humanization working groups, an ombudsman, system of qualified listening for users and workers, individual treatment projects, health care worker training programs and co-managed atmosphere projects, among others, aiming to use these tools as strategies to promote changes in the health care and management model.[a]

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Article based on the master's dissertation of Nora C.R.D., entitled: "Política de humanização na atenção básica: uma metassíntese", presented to the *Universidade do Vale do Rio dos Sinos*, Sao Leopoldo, RS, Brazil, in 2012.
The authors declare that there are no conflicts of interest.