REVIEW ARTICLE

Acceptance in Family Health teams: an integrative review*

Acolhimento nas equipes de saúde da família: uma revisão integrativa

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ABSTRACT

An integrative review was conducted in order to evaluate available evidence in the literature on the acceptance of Family Health Teams (FHT). The bibliography covered national and international publications available on the Virtual Health Library, from which 42 references were identified. The results revealed differences between the concepts of acceptance and healthcare practices in family health units. More effort must be put in developing research to maximize how professionals in the FHTs offer assistance so as to enable theory/practice integration.

Key words: User Embracement; Family Health; Patient Care Team.

RESUMO

Foi realizada revisão integrativa com o objetivo de buscar e avaliar evidências na literatura acerca do acolhimento nas equipes de saúde da família (ESF). O levantamento bibliográfico abrangeu as publicações nacionais e internacionais, disponibilizadas na Biblioteca virtual em saúde, sendo identificadas 42 referências. Os resultados revelaram divergências entre os conceitos sobre o acolhimento e as práticas assistenciais das unidades de saúde da família. É necessária a identificação de esforços para o desenvolvimento de outras pesquisas e maximizar a assistência dos profissionais nas ESF, a fim de possibilitar a integração da teoria com a prática.

Palavras-chave: *Acolhimento; Saúde da Família; Equipe de Assistência ao Paciente.*

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INTRODUCTION

In the 1970s and 80s, the Brazilian setting was characterized by several diseases, scarce funds, low quality of health services, a dissatisfied population, and insufficient healthcare coverage.[1] In response to these problems, the Sanitary Reform movement was put into effect and fought for changes in health policies. Held in 1986, the VIII National Health Conference represented the most important event for changes in the country's health sector. Two years later, the Constituent Assembly established the 1988 Constitution. As regards health, we can highlight three main aspects, namely: a more encompassing concept of health (considering physical, biological, socioeconomic, and cultural aspects); health as a universal right and the government's duty; and the establishment in 1990 of the Unified Health System (SUS)[2].

The SUS universalized access to health services and defined that Primary Health Care (PHC) should be the gateway of users to the service network[1]. Even after its

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creation, health service in Brazil was not satisfactory, given that its principles and guidelines were not applied. Aiming to address these issues, the Brazilian Ministry of Health created strategies that include the Community Health Agents Program (PACS) in 1991 and the Family Health Program (PSF) in 1994.

Since 2006, the PSF no longer has the status of a simple program; it is now regarded as a reorienting strategy for organizing the SUS. This proposal is based on the principles of territorialization and customer registration, establishing a relationship with the population, guaranteeing complete, interdisciplinary service based on team work with an emphasis on health promotion and the strengthening of intersectoral initiatives, fostering community involvement.[3]

Some authors assert that the Family Health Strategy has focused solely on territorialization and customer registration and that the SUS principles and guidelines are not being followed. It is their belief that this proposal ensures that a centered and exclusionary hegemonic medical model remains in place, with service being delivered on first come basis to the detriment of achieving the goal of reorienting the assistance model.[4,5]

Before becoming a strategy for reorienting the assistance model, the FHS was was an extension to the SUS service coverage. In order for its principles to become effective, it is necessary that the work process be reorganized in the microspaces, based on the different geographic, sanitary, and social realities of each community, using receptiveness as the guiding principle.

According to Brasil[6], receptiveness is not a space or a place, but an ethical posture that does not presuppose a specific time or professional to do it. It implies sharing knowledge, anxieties and inventions, taking on the commitment to "shelter and wrap up" those seeking the service with responsibility and efficacy as the case in hand may require.

The meaning of the verb "to accept" suggests an act of receptiveness, that is, to receive, to answer, to listen and to identify grievance or need. In this approach receptiveness is a process, result of a health practice, and constitutes a set of actions performed in different ways, bearing in mind that, in such practices, the subjects performing them determine themselves and are historically and socially determined in the context of their country's social policies.[7]

> Receptiveness means the humanization of care, which presupposes a guarantee of access for everyone (universal accessibility). It also involves listening to users' health problems in a qualified way, providing positive feedback and being committed to solving the problem. Consequently, receptiveness must ensure resolution, which is the ultimate goal of the health work, and effectively address the users' problems. Accountability for the health issues goes beyond care itself; it also concerns the necessary bond between the service and the user population.[8]

Receptiveness also provides new meaning to team relations, which need to interact during the process of assistance, building a "conversation network" that enhances their resolving capacity through exchange of knowledge and practice among professionals.[9]

It consists of changing the work processes based on individual and collective needs and demands of customers, whose main guidelines must comprise: humanization of relations in healthcare, qualified listening, access, bonding between professionals and community, accountability, solving ability, citizenship and a shift of focus from the doctor to the team.[10]

Receptiveness requires the participation of all healthcare professionals, with efficient interaction and satisfactory relationship between them, as well as the receptivity of users. Different professionals must complement one another, and complementarity emerges as element that that goes beyond individual practice, a mindset still prevailing in the education and performance of health professionals.[11]

It is therefore important that receptiveness be put into effect in family health teams in order to highlight the service qualification strategy in the SUS, to ensure user rights, as well as the responsibilities of the health services. Experience has shown that receptiveness in family health teams varies in its nuances and approaches regarding receptiveness practices and policies, which follow theoretical-conceptual contributions that do not always converge.

The objective of this study was to evaluate the available evidence in the literature about receptiveness in family health teams. It includes a bibliographical research on scientific evidence of the relationship between concepts of receptiveness and the results of primary studies carried out about receptiveness in these teams, identifying how they were delineated as well as possible shortcomings of studies on the relationship proposed in this review, in order to contribute to the development of future research.

MATERIALS AND METHODS

The literature included works published in English, Portuguese and Spanish available through the virtual health library (BIREME) on the practice of receptiveness in family health teams.

We used an integrative literature review, defined as that in which the completion of previously conducted studies is summarized so that conclusions can be made about a specific issue.

Broome[12] emphasizes that the goal of his review is to deepen the understanding of a phenomenon and this is crucial for conceptual development since it allows, through previously produced knowledge, to highlight the gaps of evidence in professional practice, thereby contextualizing researchers on a given theme.

A successful integrative review requires the same standards of accuracy, clarity and the possibility of replicating results used in primary studies, making it possible to understand of a phenomenon by means of the scientific knowledge already evidenced in the literature.[13]

This kind of research allows us to identify professionals who investigate the subject matter of interest, to establish an overview of the current knowledge and the implications of scientific knowledge in professional practice.[14]

It is important to highlight that this is a secondary and retrospective study, and thus depends on the quality of the primary source.

In this study we used the methodological concepts developed by Broome[12] and Whittemore and Knafl[15], which establish some standards to be followed by means of the following steps:

- identifying the guiding question;
- keywords;
- and;
- inclusion/exclusion criteria;
- selection of studies;
- sample of studies;
- establishing information to be collected (objectives, methodology, instruments used and conclusions reached);
- analysis of included studies (results and discussion). These authors are unanimous in highlighting the importance of structuring the research question carefully, systematizing the search for studies and analyzing results thoroughly for the sake of a well-conducted integrative review.

The question guiding the research consisted of: what is the scientific knowledge produced about receptiveness in family health teams?

The descriptors used were receptiveness and family health.

In this research we included: studies published in journals indexed in the virtual health library in the Literature Latin American and Caribbean Health Sciences (LILACS), Brazilian Dentistry Library (BBO), on Adolescence Health (ADOLEC) and Scientific Electronic Library Online (SciELO) databases, in Portuguese, English or Spanish; studies that featured, in their titles or abstracts, an analysis of receptiveness in family health teams.

The exclusion criteria meant that studies that upon reading did not approach the receptiveness in family health teams were not included.

Broome[12] emphasizes that the purpose of this step is to summarize and document, easily and concisely, the information in the articles included in the research.

Data collection took place from December 1, 2008 to January 30, 2009. There were no limits as to the year of publication. The result of this search resulted in 42 references, three of which were repeated in different databases, which resulted in 39 references in LILACS, one from BBO, one from ADOLEC and three in SciELO. The sample was located from the database itself through a manual search and interlibrary loan system (COMUT) of Universidade Federal dos Vales do Jequitinhonha e Mucuri (UFVJM). After that, the studies were carefully and thoroughly read so the ones pertinent to the subject matter could be included.

The following were recorded:

- identification of the original work (title of the article, journal, authors and their titles, language, host institution);
- methodological characteristics of the study (type of publication, purpose, population, sample, type of study design, approval by the Research Ethics Committee, informed consent, year of data collection, year of publication, selection and composition of the sample, description of the subject matter, concepts of receptiveness proposed by the authors and their recommendations, findings, and conclusions);
- database: how to obtain the full article.

The selected studies and their respective data collection instruments were numbered on the upper right corner, in ascending numerical order, by time of publication.

RESULTS AND DISCUSSION

Of the initial sample, 100% of the 42 references made their abstracts available,19 of which met the inclusion criteria; however, one was repeated and the full text of two was not available even after the authors were contacted and other attempts were made, which resulted in the sample being considered lost. Hence, 17 articles were located from the virtual health library, 12 of which (63.15%) were acquired in the database itself by means of a manual search, and five (26.31%) by the COMUT system of the UFVJM library.

The reading and subsequent analysis of the preselected studies resulted in the exclusion of one study; hence, 16 articles comprise the final sample of this review.

The 16 articles comprising the sample were published in 12 journals, with no significant discrepancy found between the journals and the year of publication. Regarding the database, LILACS published 100% of the works, followed by SciELO (31.25%). It should be noted that some of the studies were published in both databases, which explains the sum of more than 100%. The language in 14 (87.5%) was Portuguese and in two (12.5%), Portuguese and English.

The titles of the 16 works' primary author was: doctor (20%) in two; master (20%) in two; master's degree candidate (20%) in three; resident physician (10%) in one; undergraduate student (10%) in one; technician (10%) in one; and six (37.5%) did not name titles. Thirteen (81.25%) articles were linked to a higher education institution, which emphasizes the importance of research in these institutions and encourages publication on this subject by healthcare professionals.

The studies were carried out according to the number of articles and their respective institutions, which were located in: the Northeast (37.5%) in six studies; the South (31.25%), in five studies; and the Southeast (31.25%) in five studies (Table 1).

By analyzing the type of research used in the 16 selected works, we can see that 52.6% (n = 10) have a qualitative approach, and 31.6% (n = 6) did not specify their approach. In seven studies, interviewing was the main instrument for data collection (43.75%), followed by observation in six (37.5%).

Considering other methodological aspects of 14 studies which had human beings as subjects of study, 35.7% (n = 6) did not specify if they underwent analysis by a Research Ethics Committee.

Table 1 - Data about 16 studies on receptiveness in family health teams from the virtual health library (VHL). Belo Horizonte Minas Gerais, 2009

N*	Title	Year	Database	Journals/doctoral theses
1	Acolhimento: uma ideia necessária.[16]	2002	LILACS	Tese
2	Acolhimento e vínculo em uma equipe do programa de saúde da família.[4]	2004	LILACS and SCIELO	Cadernos de Saúde Pública
3	Descrição e análise do acolhimento: uma contribuição para o programa de saúde da família.[17]	2004	LILACS and DEDALUS	Revista da Escola de Enfermagem da Universidade de São Paulo
4	Acolhimento no Programa de Saúde da Família: um caminho para a humanização da atenção à saúde.[11]	2004	LILACS	Cogitare Enfermagem
5	Acolhimento como estratégia de humanização no cuidar de enfermagem do PSF: discurso de enfermeiras.[18]	2005	LILACS	Tese
6	Acolhimento e vínculo: práticas de integralidade na gestão do cuidado em saúde em grandes centros urbanos.[19]	2005	LILACS and SCIELO	Interface comum. Saúde educação
7	A implantação do acolhimento no processo de trabalho de equipes de saúde da família.[20]	2006	LILACS	Espaço e Saúde
8	Da fragmentação à integralidade: construindo e (des)construindo a prática de saúde bucal no Programa de Saúde da Família (PSF) Alagoinhas, BA.[21]	2006	LILACS	Ciência e Saúde Coletiva
9	O acolhimento no cotidiano dos profissionais das Unidades de Saúde da Família em Londrina, Paraná.[22]	2006	LILACS	Tese
10	Estudo da demanda espontânea em uma unidade de saúde da família de uma cidade de médio porte do interior de Minas Gerais.[23]	2006	LILACS	Revista Mineira de Enfermagem (REME)
11	Acolhimento e transformações no processo de trabalho de enfermagem em unidades básicas de saúde de Campinas, São Paulo, Brasil.[24]	2007	LILACS and SCIELO	Cadernos de Saúde Pública

Continues...

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Table 1 - Data about 16 studies on receptiveness in family health teams from the virtual health library (VHL). Belo Horizonte Minas Gerais, 2009

N*	Title	Year	Database	Journals/doctoral theses
12	Linhas de tensões no processo de acolhimento das equipes de saúde bucal do Programa de Saúde da Família: o caso de Alagoinhas Bahia, Brasil.[25]	2007	LILACS and SCIELO	Cadernos de Saúde Pública
13	Construindo saberes e práticas: o projeto de humanização em Petrolina, Pernambuco.[26]	2007	LILACS	Divulgação, saúde e Debate
14	Acesso e acolhimento na atenção básica: uma análise da percepção dos usuários e profissionais de saúde.[27]	2008	LILACS and SCIELO	Cadernos de Saúde Pública
15	Acolhimento: concepção dos auxiliares de enfermagem e percepção de usuários em uma unidade de saúde da família.[28]	2008	LILACS	Espaço e Saúde
16	Avaliação da proposta de acolhimento implantada na unidade de saúde da família: Nova Brasília, no Complexo do Alemão, Rio de Janeiro (RJ).[29]	2008	LILACS	Monografia de Residência.

* The letter N refers to the number the articles were given based on year of publication

It is noted that the receptiveness in family health teams defined by the authors must provide a reorganization of the working process [4,17,18,19,20,24,26,27,29], be put into practice by the whole team[4,17,19,20,-27,29 25], increase access to services[17,19,24,26-29] and provide improved solvability of actions[4,22,25,26,29] through qualified listening[11,18,19,22,25,26] in order to create links between professionals and users[11,18,22,26,27,29].

Concerning the results of the primary studies, the practice of receptiveness was considered an activity restricted to the reception[4,11,17,19-22,24-26] with activities being directed to medical consultation[4,11,17,20-25,28] by spontaneous demand[4,20-25,29]. In none of the articles were all team members identified as being responsible for receptiveness.

These results reveal some divergences between the concepts of receptiveness assigned by the authors and the assistance delivered by family health teams.

The articles, in general, include extensive literature review related to the subject; we highlight that one of them was restricted to an account of the author's experience with no mention to theoretical or bibliographic support.

The objectives, in the vast majority, are to analyze and describe the process of team work based on receptiveness, the opinions of professionals and users about its introduction and development, and the results of this practice.

Following the concepts of receptiveness assigned by the authors, the studies were divided into two theme groups:

a. receptiveness being responsible for organizing health service: changes in the work process: receptiveness is not an isolated situation, but a process that entails ensuring access, bonding, accountability, efficacy and autonomy of the subjects involved and which seeks to provide users some answers, even when these are not immediate solutions to their problems and which must fundamentally culminate in the restructuring of the entire team work process. It ought to be an instrument for changing the hegemonic model centered on disease. The work processes and the management should moreover become an object of discussion within the teams, so that they can rethink their service offer, priority programs and the organization of work in the health teams, as needed. Moreover, receptiveness should be a project for the whole team and should create conditions for actions of dehospitalization and expansion of function within the basic network. Such innovations result both from the team work process and from the organization of units into assistance networks, seeking an approximation between the supply of actions and services and the needs and demands of the population;
b. receptiveness humanized listening (kindness): receptiveness appears as a posture for humanized, sensitive listening in all health actions pursued. It goes beyond just saying good morning or calling someone by his or her name, it also involves actions that make it possible to meet the needs and solve the health problems presented daily by users by listening to them, thus setting in motion a humanized relationship (of kindness). It happens in the microspaces of individual and collective relations, whether at the reception, in the clinic, in the type of access, in lectures and meetings held, in the type of service offered, among other relational and communicational forms that exist between health workers and users. There is recep-

tiveness only when there is dialog, listening and involvement with another person's complaints in an attempt to solve the problems presented by users, in which co-accountability and pursuit for the best care are imperative.

FINAL CONSIDERATIONS

We conclude through this integrative review that receptiveness is conceptualized differently by the authors and the social practices of family health units in their primary studies. We should stress that in spite of these differences one can infer that receptiveness as a theoretical framework is defined as a posture, a technique and a form of organization of the work.

As regard the posture, communication is understood to be the way to professionals and users relate to each other and how they are received, listened, and guided. As a technique, it is understood as the professional who carries out the activities, staff appreciation, extolling the abilities and potential of the professionals involved with efficacy, bonding and accountability of all health professionals, not focusing solely on medical knowledge. The organization of the work involves the entire process mentioned above along with the coordination of the assistance in the healthcare network, based on SUS guidelines of universality of access, comprehensiveness, and equality. In practice, receptiveness has been established a new activity in family health units in an attempt to organize the service. It is performed by a few health professionals, is still focused on healthcare and fails to use the potentialities of other team members.

It is critical to think of receptiveness in light of its theoretical and practical aspects so that it can generate healthcare that complies with the SUS guidelines. It must not be merely another activity offered to the population since receptiveness is instilled in every meeting between practitioners and users and practitionerts themselves. It should be articulated with the technological advances so as to improve healthcare environments and the working conditions of professionals.

It should be noted that this study, which aimed to collect and assess evidence in the literature about receptiveness in family health teams, found that much has been achieved in that regard and that there is an extensive bibliographic production. However, we can see that the proposal is still under construction and that there are some gaps. Therefore, we need to identify efforts to produce further research and to maximize assistance of family health team workers in order to enable the integration of theory and practice.[30]

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