

SPIRITUALITY, RELIGIOSITY AND RELIGION ON PUBLIC HEALTH POLICIES: A LOOK AT INTEGRALITY**ESPIRITUALIDADE, RELIGIOSIDADE E RELIGIÃO NAS POLÍTICAS PÚBLICAS DE SAÚDE: UM OLHAR PARA A INTEGRALIDADE****ESPIRITUALIDAD, RELIGIOSIDAD Y RELIGIÓN EN LAS POLÍTICAS PÚBLICAS DE SALUD: UNA MIRADA PARA LA INTEGRALIDAD**

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The term integrality has a polissemic character which has been seeking to overcome the care fragmentation and includes health from the interaction of physical, mental, social and spiritual factors. This study aimed to identify and analyze the approach of the terms "spirituality", "religiosity" and "religion" in Brazilian health public policies from the perspective of the integrality. It was a documentary study that investigated the presence of public policy in the Virtual Health Library (VHL). From 67 policies published, 65 were available for study and were analyzed in two stages. Results revealed a subtle and superficial approach of the issue in investigated documents. Practices of health professionals are based on ideas proposed by public health policies and in this way, it is believed that the guidelines of these documents aimed at a more subjective dimension of individuals, considering the "spirituality", "religion" and "religiosity" should be strengthened, in order to produce a comprehensive care.

Descriptors: Health policy; Spirituality; Religion.

O termo integralidade possui um caráter polissêmico que tem buscado superar a fragmentação do cuidado e compreende a saúde a partir da interação de fatores físicos, mentais, sociais e espirituais. O presente estudo tem como objetivo identificar e analisar a abordagem dos termos "espiritualidade", "religiosidade" e "religião" nas políticas públicas de saúde brasileiras na perspectiva da integralidade. Tratou-se de um estudo documental que investigou as políticas públicas apresentadas na Biblioteca Virtual em Saúde (BVS). Das 67 políticas publicadas, 65 estavam disponíveis para pesquisa e foram analisadas em duas etapas. Os resultados apontaram uma abordagem sutil e superficial da temática nos documentos investigados. As práticas dos profissionais de saúde são embasadas no ideário proposto pelas políticas públicas de saúde, desta forma, acredita-se que as orientações destes documentos voltadas para uma dimensão mais subjetiva dos indivíduos, considerando a "espiritualidade", "religião" e "religiosidade", devem ser fortalecidas, com vistas na produção de um cuidado integral.

Descritores: Política de saúde; Espiritualidade; Religião.

El término integralidad tiene diversos sentidos que ha tratado de superar la fragmentación de la atención de la salud e incluye desde la interacción de factores físicos, mentales, sociales y espirituales. El presente estudio tuvo como objetivo identificar y analizar el enfoque de los términos "espiritualidad", "religiosidad" y "religión" en políticas públicas brasileñas en la perspectiva de la integralidad. Fue un estudio documental que investigó la política pública presentada en la Biblioteca Virtual en Salud (BVS). De las 67 políticas publicadas, 65 estaban disponibles para su estudio y siendo analizadas en dos etapas. Los resultados revelaron un tratamiento sutil y superficial de la cuestión investigada en los documentos. La práctica de los profesionales de la salud aquí se basan en las ideas propuestas por las políticas de salud pública de esta manera, se cree que estos documentos de orientación dirigidos a una dimensión más subjetiva de las personas, teniendo en cuenta la "espiritualidad", "religiosidad" y "religión" debe fortalecerse, con el fin de producir una atención integral.

Descriptor: Política de salud; Espiritualidad; Religión.

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INTRODUCTION

Verb to integrate comes from the Latin verb *integer*, producing a sense of completeness, of action in which the parts are formed of a whole and they compose the set. The term "integrality" has a polysemic character, which in the historical process of scientific discussion has sought to overcome the fragmentation of the Human Being¹⁻³.

In Brazil, the use of the term became relevant in the late 70s and early 80s of last century, in the health reform context, in government policies and intervention programs. The incorporation of integrality as a guiding principle for structuring the State policy for health aims to guide the organization of services in this area and strengthen the struggle for creation of a universal, accessible and quality health care system¹.

In this context, integrality associated with the guiding principles of health practices values human subjectivity, offering the possibility for dialogue and the integration of various forms of health action⁴.

It is believed that looking at the subject in their way of relating to life may contribute to enlarge the social understanding of the demands of the health system users and enhance the care for the individual and their needs⁵. This holistic approach, which represents a paradigm shift in the understanding of the health-disease process, previously primarily biomedical and currently focused on quality of life.

In this sense, the resolution published in the Amendment to the Constitution of April, 7, 1999, included the spiritual realm in multidisciplinary health concept⁶. There has been a broadening of the concept of health of WHO (World Health Organization), which is no longer exclusively the disease, giving way to the study of adaptive traits such as resilience, hope, creativity, courage and spirituality, thus, the health of individuals is

determined by the interaction of physical, mental, social and spiritual factors⁷.

The relationship between health and spiritual factors has become a current topic of interest to many studies, in view of the observation of its influence on the well-being of people⁵. This scenario has been a source of discussion, because for years the spirituality and religiosity were considered as synonyms, until, in the early nineteenth century, these concepts began to show distinctions. However, they are still subjects difficult to approach by health professionals, which raises a broad debate in search of a consensus⁸.

Concepts such as religion, religiosity and spirituality are commonly used interchangeably, even as synonyms, although they have different meanings⁹.

It is not always easy and convenient to speak of spirituality in health, given the breadth of the subject, its subjective nature inherent in the popular imagination and the demand of the society for professionals due to the close relationship of legitimacy between health and science¹⁰.

Spirituality word derived from the Latin *spiritus*, meaning the essential part of the person that controls the mind and the body; etymology of the word spirituality signifies breath of life and it is related also to the significance of life and reason to live, not limited to types of religious beliefs or practices, but related to the search for transcendence, which goes beyond that in the dogmas of traditional religions^{11,12}.

Religiosity, on the other hand, is taken as the value of religious experience, not necessarily is identified with a particular religious tradition such as a system of rites, practices, doctrines, and thus it is not linked to a particular religious community as the only way capable of providing the connection to divine being. Individuals incorporate ritual and doctrinal elements of different religions in personal arrangements¹³.

In turn, the etymology of the word religion comes from the Latin - *religare*, meaning "re-unite", i.e., "re-connect man to

his divine essence" that is clarified as an organized system of beliefs, practices, rituals and symbols designed to facilitate proximity to the sacred and the transcendent and often involves symbols, rituals, ceremonies and bring explanations about life and death^{11,14,15}.

There relevance of understanding of such phenomena, since Brazilian public health system and other care groups seek to reorient their care practices to better fit the cultural and subjective reality of the population served by health professionals⁵.

A national population study, involving 3,007 participants from a representative sample of the Brazilian population found that only 5% of Brazilians reported having no religion, 83% considered the religion very important for their life and 37% attended a religious service at least once a week¹⁶. Religious affiliations most frequently identified were: Catholicism(68%), Protestant/Evangelical(23%) and Kardecist Spiritualism(2.5%)¹⁷.

Under spirituality, religiosity and religion, it is considered that studies in this direction are particularly relevant in a country where people manifest a variety of religious and spiritual beliefs that can influence the health of the population⁵.

The prism of health public policies to address the issues spirituality, religiosity and religion are important, since policies are government responses to demands, problems and conflicts that arise in society¹⁸. In this sense, understanding the organization of macro level political services allows us to enlarge the actions towards humanization, reception and care ethics with the individual¹².

Serving healthcare users as a whole being, including assistance in the sense of spirituality, religiosity and religion as resources for health production, means valuing their history and the ways in which people relate to life⁵.

This research aimed to identify and analyze the approach of the terms spirituality, religiosity and religion in

national public health policies, from the perspective of completeness.

METHOD

It was a documentary research with a qualitative approach, aimed to identify the themes "spirituality", "religion" and "religion" in national public health policies.

Methodological choice is justified by the influence and social relevance of the documents analyzed, since public policies are guidelines and guiding principles of action of the government and involve decisions in order to satisfy the interests of the community, from structured strategies in a decision-making process consisted of complex variables that impact reality^{19,20}. In summary, public health policies are linked to economic, political, cultural and ideological, processes and their practices relate to the social development of a country²¹.

In this context, the present study sought to investigate the public health policies, present in the Virtual Health Library (VHL) and imposed by the Ministry of Health²².

The VHL is developed under the coordination of the Latin American Center on Health Sciences Information (BIREME), and it is a decentralized and dynamic online information network. It differs from the set of information sources available on the Internet because it obeys the selection and quality control criteria, which provides a combined space among users, intermediaries and information producers²².

The collection of public policies present in VHL was treated in two steps, namely:

- Step 1 - Analysis of the identified terms

Survey of available documents and preliminary document analysis, which included: analysis of context, authors, authenticity and reliability, text nature, key concepts and internal logic²³. Documents considered suitable were submitted to content analysis, which consisted of directed search and interpretation of the

appearance of the central terms "spirituality", "religiosity" and "religion," and related terms^{24,25}.

After the literature review and exploratory reading of books and indexed articles related to the research, it was possible to list terms that have correlation with the guiding central words of the research.

- *Step 2 - Policies that propose in their title the word integrality or integral*

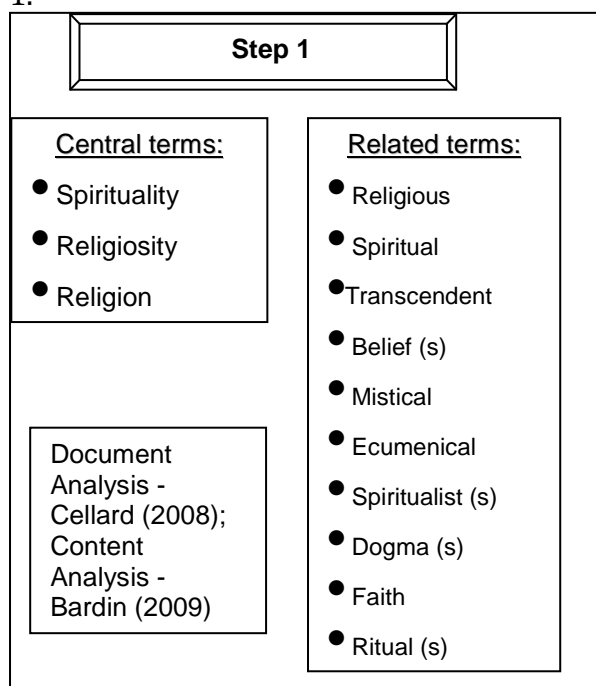
It involved identifying and analyzing public health policies that proposed, in their titles, the words "integral" or "integrality" in order to investigate in greater depth possible relationship of the proposed integrality with the studied theme. These documents, after selected, were submitted in full to content analysis, which consisted of three chronological poles, namely: pre-analysis; material exploration and treatment of results; inference and interpretation²⁴.

In both steps of the method, access to policies occurred in the period from July, 1, 2013 to October, 31, 2013.

RESULTS

Table 1 presents the central terms, in the study, referring to step 1.

Table 1: Data Collection/Step 1.



Of the 67 public policies located in the VHL collection, two had unavailable access during collection, they are: National Policy for Information and Health Informatics: Proposal 2004; Monitoring System of Policy for Incentive on the Scope of the National STD and AIDS Program: Ordinance No. 1679 of 08/13/2004.

The 65 analyzed policies are available in the VHL through the link *policies and SUS guidelines - National Policies*. They are cited randomly, composed by title, year and edition. According to the year, the oldest is from 1990 - Federal Policy for Pharmaceutical Assistance; and the latest is from 2011 - National Policy for Integral Health of Populations in Rural Areas and Forest (PNSIPCF).

These are health policies that address more specifically issues such as: humanization; chronic diseases; information system; Unified Health System management; alcohol and other drugs; pharmaceutical services; food/nutrition; primary care; men's health; women's health; assisted human reproduction; attention to the emergency; integrative, complementary and herbal practices.

With regard to identification of the central terms (religion, spirituality and religiosity), only the term religion became evident in the documents, a total of five appearances (n = 5), as follows: once (n = 01) in the National Policy for Integral Care of Women's Health: Principles and guidelines, 2004; three times (n = 03) in the National Policy for Integral Care of Black Population, 2007 and once (n = 01) in the National Policy for the Promotion of Racial Equality. The other central terms did not appear in any researched policy.

After identification of the central terms, the research in the documents continued with search for related terms, registering a total of thirty-six appearances (n = 36). Only some are presented for illustration, given the descriptive volume.

In a total of seventeen times (n=17) in which the correlate term religious appears, they are cited and linked to a

context, but without explanatory conceptual definitions and with emphasis of the authors under the terms. According to the concepts considered in this search for the terms spirituality, religiosity and religion, these appearances allow different inferences. The following excerpts illustrate this statement:

*"[...] XXI – to establish and deploy the host and a humane approach, based on a user-centered model and their health needs, respecting the ethnic, racial, cultural, social and **religious** diversity"*²⁶.

*"[...] XVII - traditional people and communities: groups culturally different that recognize themselves as traditional, have their own forms of social organization and occupy and use territories and natural resources as a condition for their cultural, social, **religious**, ancestral and economic, production and reproduction, using knowledge and practical innovations generated and transmitted by tradition"*²⁷.

*"[...] Despite legal system grants a set of laws concerned with the equality in individual and political rights (of which freedom of **religion** would be example), social rights, educational rights, cultural rights, among others, statistics indicate that such rights are far from being effective, this being up to the federal government"*²⁸.

The term belief(s) appeared in a total of fourteen times (n=14), and in seven (n=7) it was not linked to the definitions considered for the central terms of this research. Some are exemplified in the following stretches, respectively:

*"[...] Service should be guided by respect for all differences without discrimination of any kind and without imposition of values and **beliefs**. This approach should be incorporated to the awareness and training processes for humanization of health practices"*²⁹.

*"[...] High rates of morbidity and mortality related to external causes among adolescents and young people are also significant, and can be understood in the light of **belief** in invulnerability and social need for self-assertion"*³⁰.

The term spiritual appeared in a total of four times (n=4), these appearances presented proximity to the studied theme, but without a clear differentiation related to some of the concepts (spirituality, religiosity and religion), as can be exemplified by following excerpt:

*"[...] Healing practices respond to an internal logic of each indigenous community and are the product of their particular relationship with the **spiritual** world and the beings of the environment in which they live. These practices and concepts are, usually, health resources of empirical and symbolic efficacies, according to the most recent definition of health of the World Health Organization"*³¹.

The correlate term transcendent appeared once (n=01) with dissonant sense of those related to the proposed central terms in this research:

*"Accidents and violence in Brazil constitute a public health problem of great magnitude and **transcendence**, which has provoked strong impact on morbidity and mortality of the population"*³².

The other related terms have not obtained any appearance, they are: Mystic, ecumenical, spiritualist, dogma (s), faith and ritual (s).

It was found that there is not a clear distinction in policies on terms about spirituality, religiosity and religion, which allows different interpretations and concepts for those who adopt these policies as principle of health practice.

From the appearances of central and related terms, it was held a review in light of the senses, proposals for integrality, understood as polysemic and supervisor of health practices that value the subjectivity of the individual and their knowledge³³.

It was observed 25 appearances connected in a timely manner to the term integrality and 1 in a depth manner; in turn, 9 appearances did not connect the integrality and 6 were terms with other concepts, as Table 2 shows.

Table 2 - Analysis of the appearance of the central and related terms.

Appearances related to the integrality- 25 (cited in a timely manner) and, - 1 (in a depth manner in the context)	Appearances unrelated to the integrality - 9	Terms with other concepts - 6
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It is noteworthy that in a total of forty-one terms (n=41) identified, twenty-five (n=25) appeared in a timely manner within the perspective of integrality, as shown in the excerpt reported by the National Policy for Integral Care to Women's Health: principles and guidelines (2004, p. 64) that says:

*"[...] comprehensive care to women's health implies, to service providers, in building relationships with individuals, whether for economic, cultural, **religious** and racial reasons, of different sexual orientations"* ²⁹.

Only one (n=01) term appeared followed by explanation and contextualized about the prism of integrality understood in this study. This appearance is proposed by the National Policy for Health Care of Indigenous People of 2002 that lists the indigenous traditional health systems to a holistic approach underpinned by principles of individual's harmony with the universe in which they live. And these concepts are agreed with the definition of health, recently advocated by WHO.

In turn, nine (n=09) central and related terms were not related to the sense of integrality approached and appeared related to aspects such as: historical moment and complement of socio-demographic data. The National Policy for Health Care of Indigenous Peoples (2002, p. 07) exemplifies the appearance related to the historical moment:

"[...] In Brazil, indigenous population, estimated at about 5 million people in the early sixteenth century, (...) was wiped out by expeditions punitive to their religious practices and their resistance movements, but mainly by epidemics of infectious diseases, whose impact was favored by

changes in their way of life imposed by colonization and Christianization" ³¹.

Another six (n=06) central and related terms did not fit in the concept of the proposed terms and neither were related to the sense of integrality. This passage of the National Policy for Integral Care to Men's Health: Principles and guidelines, 2008, p. 15 exemplifies the statement:

*"[...] High rates of morbidity and mortality related to external causes among adolescents and young people are also significant, and can be understood in the light of **belief** in invulnerability and social need for self-assertion"* ³⁰.

Policies that propose in their titles the word integrality or integral

After the outcome of the first stage, policies that proposed in their titles the words "integral" or "integrality" were analyzed in full.

It was found that among the sixty-five (n=65) documents available in the VHL, nine (n=9) met the proposed criteria: Integral Care Policy to Users of Alcohol and Other Drugs (2003), National Policy for Integral Care to Men's Health (2009), National Policy For Integral Care to Men's Health: principles and guidelines (2008), National Policy for Integral Care of Woman's Health - action plan (2004-2007), National Policy for Integral Care of Women's Health: Principles and guidelines (2004), National Policy for Integral Care on Assisted Human Reproduction (2005), National Policy for Integral Care for Black Population's Health (2007), National Policy for Integral Health of Populations in Rural Areas and Forest (2011), Summary of Guidelines for Integral Care Policy for Women's Health (2004-2007).

From the analysis of national public policies mentioned, it was observed that the researched subject, including the terms spirituality, religiosity and religion, did not appear significantly beyond what was identified in Step 1. As for the principle of integrality, it has been identified as a priority the meaning that involves the

organization of services for the production of a comprehensive care, standing up to the direction facing the subjectivity and cultural diversity of the subjects.

It was observed that the dialogue involving the proposals Humanization and Host in policies has a significant relationship with the adjacent concepts of studied terms, although this did not appear explicitly.

DISCUSSION

Results of the analysis of public health policies in the study showed a subtle and not explanatory approach of the studied subject, which indicates the need to expand the discussion of issues related to spirituality, religiosity and religion with respect to production in health, care since the analyzed documents are seen as guiding the actions in public health²⁰.

Regarding the identification of central and related terms investigated in the study, we observed the predominance of appearance of the words "religion" and "religious" in the researched policies. This finding is in agreement with theoretical discussions on the topic, which point this relationship as originating from the earliest times, as humans seeking to assign meaning to life and religion appears as a major source of inspiration¹³.

In this context, the search for knowledge fosters a historically conflictual relationship between religion and science fields³⁴. However, this scenario is changing in recent decades, because there has been a change in health paradigms with the inclusion of spiritual aspects, which enables bring to the scientific field discussions on these topics and a complement of knowledge between both^{33,34}. These considerations confirm the need to understand and deepen the impact of religious and spiritual aspects of the individual's life, given its inference and impact on the health-disease process.

It is possible to identify in the literature of the area and in official public documents the consideration of the

importance of these aspects in the production of health care. In this context, we highlight the Federal Constitution of 1988, in Art. 5 paragraph VII, which addresses to the provision of religious assistance in civil and military establishments of collective confinement and Law No. 9,982/2000, which guarantees access of religious people to public and private hospitals, subject to compliance with the wishes of patients and/or family and the rules of each institution³⁴. However, the research results point to a still limited and little consistent approach on how health care is related to this topic and how it should be produced accordingly.

Furthermore, it is important to highlight another result of the study, which points to the appearance of central and correlate terms in an unclear and little specific manner with regard to the differentiation of the concepts of each term. In most appearances, it was not possible to say whether the term referred to the concept of religion, religiosity or spirituality advocated by the main authors of the area used in the study, giving ground for different interpretations for the same term.

This is not to limit the approach of the terms, however, it is believed in the importance of creating opportunities for conceptual differentiation in policies, since the approach of the theme in the practices will be influenced by the professionals' beliefs, which will not always ensure valuing diversity in the health context. Thus, expanding the discussion towards the differentiation of these terms can open paths to a more consistent reflection on the different ways to experience the spiritual dimension, with a view to strengthen more diverse and welcoming practices.

Step 2 of the research sought to understand how the content of policies that bring in their title the word integrality/integral and that approach the subject studied and the results reinforced those obtained in the first step. It was

expected that these policies foster discussion about important aspects of subjectivity and culture of subjects such as religion, spirituality and religiosity, according to the polysemic definition of the term integrality, which did not happen. However, we observed an approach of these issues from the concepts related to the proposal of humanization and host present in the documents examined, although it has not been identified this relationship directly presented.

It was found, in most of the policies, humanization as a guideline, and it was made during the search a relation between humanization and the theme of study. This relationship indicates that the humanization is a form of assistance that values quality of care and is associated with recognition of patients' rights, their subjectivity and cultural references³⁵.

Similarly, it was possible to observe association between study theme and the proposal of host, since this is seen as an ethical stance which implies listening the user about their needs, in recognition of their role in the health-disease process and commitment of response to the needs of citizens seeking health services³⁶.

It was also observed in the analyzed documents a prevalence of completeness approach related to the organization of services as a way to guide health practices³⁷. It is believed that this result may be a factor influencing the small approach to spirituality, religiosity and religion themes, as this discussion approaches mainly of another sense of integrality, that focused on attention to the subjectivity of individuals, and less discussed in documents.

The Brazilian Federal Constitution of 1988 points the comprehensive health care as one of the guidelines of Unified Health System and, since then, integrality has been placed as a central issue in government policies, intervention programs and throughout health movement speech²⁵. Integrality in the context of Unified Health System can be seen as an image-goal with

various senses that brings together three sets: (1) completeness as a trait of good medicine, (2) as a way of organizing practices and (3) as government responses to specific health problems³⁸. In the first set of senses, a trait of good medicine, completeness consists of a response to the suffering of the person seeking help on health care, taking care that it is not limited to the biological system⁹.

Integrality in health care refers to the valorization of inter-subjective practices, in which professionals relate with subjects and not objects, in a dialogical dimension³⁹. In this direction, we reaffirm the need to consider the comprehensive care for the individual, the aspects of spiritual life, since it is a dimension component of social and cultural human experience and therefore of the daily life most of the population⁴⁰.

In view of this, we highlight the importance of equal valuation of different senses that make up integrality, in order to achieve complementarity of different actions, which are brought in health practices and can meet the individual in its complexity.

The National Policy for Health Care of Indigenous People (2002) was the one that presented a direct and deepened approach of the subject investigated in the study. This document included the indigenous participation in all its development (implementation, evaluation and improvement).

It is believed that this concern, active participation of the central stakeholders in the development of the policy, may account for the clear and deepened defense of the importance of considering the spiritual aspects in health process aimed at this population. In this sense, health care is not just a technical procedure, but an integral action with meanings and senses related to the understanding of health as a right to be; and thinking the right to be in health system is to respect the differences of individuals and enable them to actively participate in the decision about the best technology used by them²⁵.

Despite this policy does not have in its title the term "integral" or "integrality", it presented closeness in content to the theme studied in the perspective of comprehensiveness and articulated the related term "spiritual" with the definition of health of the World Health Organization Amendments to the Constitution of 1999, which adds the spiritual aspect to the other domains (physical, psychological and social). Throughout the history of civilization, there are records of cults and rituals that illustrate man's connection with the transcendent, which can also be observed in contemporary societies³⁴. This policy has proposed a liaison with knowledge and practices of indigenous population, thus allowing the development of a policy that enables the achievement of health improvements consistent with the cultural reality.

Close to the proposed policy for the health of indigenous people, we identified the National Policy for Popular Education in Health, approved in Ordinance No. 2761 of November 19, 2013, therefore, not yet in force and constituting the collection of VHL until the date of data collection for this study.

This policy is proposed by the Ministry of Health, through the Department of Strategic and Participatory Management, and reaffirms the principles of the Unified Health System and the commitment to guarantee life and reduce social inequalities, grounded in the expansion of participatory democracy in the health sector. Based on the theoretical framework of Popular Education in Health, it considers knowledge as social-historical production of the subjects built from the dialogue and defends that the values and principles present in popular care practices contribute meaningfully significantly to the promotion of the autonomy of the citizen, which is the protagonist of their health projects⁴¹.

It is identified in this policy a significant discussion in the issue highlighted in the study, when it explains

the importance of considering spirituality in the scenario of Popular Education. The paper reports that spirituality is an important dimension in the practices of Popular Education in Health and it is responsible for guiding and providing direction to the most fundamental choices in people's lives¹³.

Therefore, it is possible that the National Policy for Popular Education in Health contributes to the deepening of the meaning of comprehensive care in this context, based on the valorization of personal and collective projects as an essential part of the care organization.

As the outcome of this discussion, it is believed that the guidelines aimed at a more subjective dimension of individuals, considering the dimension of the "spirituality", "religion" and "religiosity", should be strengthened in national public health policies, towards producing a more comprehensive care. This statement converges with the results obtained in the study and becomes relevant since the practices of health professionals are based and guided in the ideas proposed by these policies.

CONCLUSION

From the perspective of integrality, it is important that health practices respect the subject in all their dimensions (physical, social, mental and spiritual).

Research showed that the public health policies in Brazil, in general, superficially present the spiritual dimension related to individual and collective health. It is believed that public participation in the development of public policies may represent a strengthening aspect in the production of more effective comprehensive care accordingly.

We highlight the initial character and the limits of research, which did not intend to exhaust the subject, rather, intended to raise indicatives for the development of other more deepened studies and reviews of the thematic approach of the guiding documents of health practices.

It is believed still in the relevance of research to investigate the impact of this approach in daily actions in different contexts of production and management of health care.

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CONTRIBUTIONS

Carolina Nantes de Castilho e Paula Tatiana Cardoso had equal contributions in the development of the research and in the elaboration of the article in its several phases.