Revista Científica Escola de Saúde Pública do Ceará Paulo Marcelo Martins Rodrigues
1808-7329 (1809-0893)

ORIGINAL ARTICLE
Public / Collective Health

UNDERSTANDING THE BOND BETWEEN NURSING PROFESSIONALS AND PATIENTS

COMPREENDENDO O VÍNCULO ENTRE PROFISSIONAL DE ENFERMAGEM E PACIENTE

COMPRENSIÓN DEL VÍNCULO ENTRE PROFESIONAL DE ENFERMERÍA Y PACIENTE

Fabianne Ferreira Costa Róseo[1], *Rosa Ferreira Neta*[2], *Amália Gonçalves Arruda*[3] e *Joice Fabrício de Souza*[4]

ABSTRACT
Objective: To investigate the factors that strengthen attachment between nursing professionals and patients in Primary Health Care. **Methodology:** Descriptive and qualitative research conducted among eight nursing professionals from Arneiroz, in the state of Ceará. Data were collected through semi-structured interviews and analyzed using the technique of content analysis from Minayo. **Results:** The results reveled that staff turnover, work overload, and Community Health Agents' undervalue obstruct the strengthening of bonds, while qualified listening, empathy, and continuity of healthcare stand out as facilitators. Final **Considerations:** We conclude that a humanized patient welcoming is essential for the Family Health Strategy consolidation, although the findings can also support the improvement of Primary Health Care in different contexts across the country.
Keywords: *Welcoming; Continuity of Patient Care; Nursing.*

RESUMO
Objetivo: Investigar os fatores que favorecem o vínculo entre profissionais de enfermagem e pacientes na Atenção Primária à Saúde. **Metodologia:** Pesquisa descritiva, qualitativa, realizada com oito profissionais de enfermagem do município de Arneiroz, Ceará. Os dados foram coletados por meio de entrevistas semiestruturadas e analisados com base na análise de conteúdo de Minayo. **Resultados:** Os resultados evidenciaram que a rotatividade de profissionais, a sobrecarga de trabalho e a desvalorização do Agente Comunitário de Saúde dificultam o fortalecimento dos vínculos, enquanto a escuta qualificada, a empatia e a continuidade do cuidado se destacam como elementos facilitadores. **Considerações Finais:** Conclui-se que o acolhimento humanizado é essencial para a consolidação da Estratégia Saúde da Família e que os achados podem subsidiar o aprimoramento da Atenção Primária em diferentes contextos do país.
Descritores: *Acolhimento; Continuidade da Assistência ao Paciente; Enfermagem.*

RESUMEN
Objetivo: Investigar los factores que favorecen el vínculo entre profesionales de enfermería y pacientes en la Atención Primaria a la Salud. **Metodología:** Investigación detallada, cualitativa, realizada con ocho profesionales de enfermería del municipio de Arneiroz, Ceará. Los datos fueron colectados mediante entrevistas semiestructuradas y se analizaron basándose en el análisis de Minayo. **Resultados:** Los resultados evidenciaron que la rotación de profesionales, la sobrecarga de trabajo y la desvalorización del Agente Comunitario de Salud dificultan el fortalecimiento de las relaciones, mientras que la atención cualificada, la empatía y la continuidad del cuidado se destacan como elementos facilitadores. **Consideraciones Finales:** Se concluye que el acogimiento humanizado es primordial para la consolidación de la Estrategia de Salud de la Familia y que los hallazgos pueden auxiliar la mejora de la Atención Primaria en diferentes contextos del país.
Descriptores: *Acogimiento; Continuidad de Asistencia al Paciente; Enfermería.*

[1] Centro Universitário do Vale do Jaguaribe. Aracati/CE - Brasil.
[2] Escola de Saúde Pública do Ceará. Fortaleza/CE - Brasil.
[3] Centro Universitário do Vale do Jaguaribe. Aracati/CE - Brasil.
[4] Escola de Saúde Pública do Ceará. Fortaleza/CE - Brasil.

INTRODUCTION

Primary Health Care (PHC) is the main entry point for users into the Unified Health System (SUS) and is responsible for organizing care and coordinating the Health Care Networks (HCNs). Its work is guided by principles such as accessibility, continuity of the patient-provider relationship, care coordination, comprehensiveness, and continuity[1]. To fulfill this role, Basic Health Units (BHUs) must be territorially accessible and capable of providing effective care, which requires teams to commit to user-centered and welcoming practices that address the needs of the population[2].

In Primary Health Care (PHC), welcoming practices are understood as an ethical and technical approach that guides qualified listening, accountability, and the shared definition of care actions with the people being served, promoting comprehensive and person-centered care[3]. In this process, the relationship between the health professional and the patient is essential, as it is built over time and based on trust, rapport, and shared responsibility[4]. According to the National Primary Care Policy (PNAB), this relationship has therapeutic potential, strengthening the care process and the user's adherence to health care actions[2].

Furthermore, the National Humanization Policy (PNH) highlights that the humanization of care involves valuing individuals, promoting autonomy and participation, and strengthening bonds of solidarity[6]. As reported by to Yamamoto *et al*.[7], the presence of a strong therapeutic relationship fosters the development of more empathetic interactions, improves adherence to treatment, and strengthens the work of primary health care teams, which directly impacts the effectiveness of health care practices.

However, despite its importance, strengthening the professional–user relationship faces significant challenges, such as high staff turnover, job instability, excessive workload, and precarious working conditions[7,8]. These elements can weaken the continuity of care and hinder the development of long-term relationships with patients, especially in vulnerable regions.

In the municipality of Arneiroz, Ceará, characteristics that exacerbate these vulnerabilities can be observed, such as political instability, which affects the retention of professionals in Family Health teams, and the territorial dispersion of the population, especially in hard-to-reach rural areas. The author of this study, with eight years of experience as a nurse in local primary health care, experiences daily the challenges involved in maintaining solid and continuous relationships with users, particularly those living in more remote communities.

These obstacles also affect the longitudinal bond, understood as the relationship built over time between users and the primary health care team – a relationship that enhances problem-solving capacity, reduces hospitalizations, and improves the quality of care[9]. Considering that nursing professionals, especially nurses, are often the primary agents responsible for ensuring continuity of care in primary health care units, it becomes relevant to investigate how this bond is established and which elements influence it.

Thus, this study is grounded in the following question: what factors influence the establishment of bonds between nursing professionals and primary health care users in the municipality of Arneiroz? How does the process of building this bond unfold? The

underlying hypothesis is that understanding the elements that facilitate or hinder the creation of this bond can contribute to more effective reception and care practices, thereby positively impacting health outcomes.

This research aimed to investigate the factors that influence the formation of bonds between nursing professionals and patients in primary health care in the municipality of Arneiroz, Ceará. The specific objectives were to: describe the practices used to establish bonds between nursing professionals and patients; assess the existing bonds between these professionals and patients; and identify the factors that shape the development of the bond in primary health care.

METHODS

This is a descriptive, exploratory field study with a qualitative approach, conducted in four Basic Health Units (UBSs) in the municipality of Arneiroz, Ceará. Two units are in the urban area and two in the rural area, corresponding to the four local Family Health Strategy (ESF) teams. Eight nursing professionals participated in the study – one nurse and one nursing technician from each unit – amounting to four nurses and four technicians, representing both areas.

Participants were selected based on meeting the inclusion criteria: at least one year of experience working at the Primary Health Care Unit (UBS), being present at the time of the interview, and providing formal consent by signing the Informed Consent Form and the Authorization for Voice Recording Form. Data collection was conducted through semi-structured interviews, consisting of seven open-ended questions and audio recording, carried out by the researcher in the nursing office of each UBS, while respecting the service routine.

The data analysis followed the Content Analysis technique proposed by Minayo[10], comprising the following steps: exploratory reading, fieldwork, and the analysis and processing of empirical material (organization, classification, and interpretation of the data). The findings were organized into thematic categories considering current scientific literature.

The research adhered to the ethical principles of CNS Resolutions No. 466/2012 and No. 510/2016[11,12], with approval from the Research Ethics Committee of the Ceará School of Public Health (Approval Report No. 7,440,661). To ensure anonymity, the nursing professionals were identified using the codes “P1” to “P8.”

To ensure the scientific quality of the study and the credibility of the results, methodological rigor criteria specific to the qualitative approach were observed. Therefore, data collection was concluded once the recurrence of statements and the absence of new relevant elements in the interviews were identified, characterizing the saturation point. Despite the small number of participants (eight professionals), considered adequate given the qualitative nature and the study context, it was observed that the analytical categories were repeated and consolidated, with no emergence of additional information.

Moreover, the data underwent triangulation among the researcher, the scientific literature, and the empirical records (transcribed statements), ensuring that the interpretations were not merely subjective. In addition, validation was sought by

comparing these statements with guidance documents from Primary Health Care and the National Humanization Policy, which reinforced the relevance of the results.

The entire methodological process was documented in detail, from the definition of the inclusion criteria, through the conduct of the semi-structured interviews, to the analysis based on Minayo[10]. This documentation ensures that another researcher, under similar conditions, can understand and follow the study's trajectory, thereby guaranteeing the reliability of the data.

RESULTS

The study involved eight nursing professionals (P1 to P8), six females and two males. Regarding age, four participants were between 26 and 29 years old, three between 30 and 45 years old, and only one was over 50 years old. The sample consisted of four nurses and four nursing technicians, working in primary health care units equally distributed between urban and rural areas. Length of service ranged from 1 year and 3 months to 8 years for nurses, and from 1 year and 5 months to 15 years for technicians (Table 1).

Table 1 – Characterization of the study subjects, Arneiroz, Ceará, 2025.

Interviewees	Professional category	Age (years)	Sex	UBS Zone	Length of service on the team
P 1	Nurse	37	M	Rural	1 year and 3 months
P 2	Nurse	45	F	Rural	2 years
P 3	Nurse	28	F	Urban	8 years
P 4	Nurse	30	M	Urban	3 years
P 5	Nursing technician	26	F	Rural	1 year and 5 months
P 6	Nursing technician	53	F	Rural	15 years
P 7	Nursing technician	27	F	Urban	7 years
P 8	Nursing technician	29	F	Urban	1 year e 8 months

Source: Survey data (2025).

The analysis of the interviews resulted in four thematic categories that highlight the dynamics of care reception and bonding between nursing professionals and users in primary health care. The first category addresses the reception of demand, which occurs both during scheduled appointments and in walk-in situations, and is characterized by triage, qualified listening, and referral. The professionals emphasized the importance of this initial stage for effective and humanized care. One nurse explained: "*Nursing reception is carried out by the technician or the nurse during triage (...). If it is a walk-in demand, an assessment is performed, and the patient is referred according to their needs*" (P1). Qualified listening was highlighted by another professional: "*In my unit, reception takes place through qualified listening, where we listen to the user's complaint and refer to them*" (P3). The measurement of vital signs was also mentioned as part of the process, integrated into the initial care.

In the second category, concerning the bond between nursing professional and user, the accounts indicated that this bond is built on trust, empathy, affection, and mutual respect. One participant summarized: "The bond is built from empathy in the relationship and trust throughout the care provided" (P8). Trust was considered central: "I consider the issue of trust that the patient creates in the professional" (P1). Close interaction with the community, while fostering the bond, also presents challenges, as highlighted by one nurse: "It's challenging because I work in the community where I live, and patients create that bond… and think we have to be available 24 hours a day" (P2).

The third category highlighted the challenges in establishing bonds, emphasizing structural difficulties such as limited access to health units and lack of transportation, especially in rural areas. One interviewee reported: "*For those working in rural areas, many patients don't come to us because of the distance... some patients live 30 km away*" (P8). The rainy season exacerbates this situation, as noted by another: "*Access difficulties in rural areas during the rainy season, overflowing dams, remote locations...*" (P1). Subjective barriers were also mentioned, such as patients' lack of interest and absence from appointments: "*Some patients don't seek care at the unit because of access, others due to lack of interest...*" (P2). The contractual instability of professionals was identified as a factor discouraging the creation of lasting bonds: "*Since I'm temporary, sometimes I think about not forming a strong bond with this community...*" (P3).

Finally, the fourth category addressed strategies for strengthening the bond, with an emphasis on active outreach, home visits, and partnerships with Community Health Agents (CHAs). CHAs were recognized as fundamental: "*They are the ones who help us in this effort to actively seek out these patients, so they come to the unit*" (P2). Joint action with social services was also mentioned: "*When a person is very resistant to vaccination, we go to their home to vaccinate them, we even call the social worker*" (P3). Furthermore, humanized care emerged as a cross-cutting strategy: "*Quality care, a welcoming environment, a humanized approach, a humanized consultation*" (P2), reinforcing that listening, respect, and empathy are pillars for establishing relationships of trust and continuity of care.

DISCUSSION

The qualitative analysis of the nursing professionals' reports showed that the reception process in primary health care units is predominantly carried out following a technical approach, with an emphasis on triage, initial assessment, and referral of users, in both scheduled and walk-in situations.

According to interviewee P1, "*nursing care reception is carried out by the technician or nurse during triage, in scheduled appointments [...], for walk-in patients, an assessment is conducted, and the patient is referred according to their needs*", revealing a standardized and functional care flow. However, this practice often prioritizes technical procedures while neglecting essential subjective aspects, such as qualified listening, empathy, and the establishment of bonds – fundamental elements for the humanization of care.

This gap is highlighted by interviewee P3, who states: "*In my unit, patient reception is carried out through qualified listening by the nursing team, where we listen*

to the user's complaint and refer to them accordingly". This account demonstrates that, despite the existence of practices aligned with the National Humanization Policy (PNH), they are not uniformly implemented across health units. According to the Ministry of Health[3,13], patient reception should be understood as a relational practice that transcends clinical triage, incorporating qualified listening, attending to the user's needs, and an ethical commitment to resolutive care.

Although technical care is essential for organizing demand, the predominance of a biomedical and mechanistic approach can compromise the establishment of bonds, reducing care to immediate referral and overlooking patients' subjectivities. This finding reinforces the results of Marques *et al.*[14], who underscore weaknesses in consolidating reception as a comprehensive and humanized practice in primary health care.

The role of nursing technicians, often responsible for triage and vital sign assessment, is crucial for the functioning of the care process. Participant P6 illustrates this: "*I perform the triage, measure vital signs, and then the patient is directed to the appropriate professional*". However, limiting practice to the technical aspect, without engaging in dialogue or qualified listening, reinforces the need for training and sensitization of the teams for a humanized approach.

Even though professionals demonstrate knowledge of the organizational flow and their roles in patient reception, heterogeneity in practices is observed, with triage and referral predominating. Consequently, reaffirming the principles of the National Humanization Policy (PNH) and Primary Health Care (APS) becomes imperative, promoting ongoing training that encourages active listening, dialogue, and co-responsibility, thus fostering comprehensive, user-centered care.

Regarding the establishment of bonds, trust was cited as the fundamental basis of this relationship, understood as a gradual process that strengthens with continuity of care. Active listening and welcoming are essential practices to reinforce this bond, allowing the patient to feel valued and understood. Ethics and respect are also highlighted as pillars supporting professional-patient relationship, ensuring dignified, nonjudgmental care.

In this sense, the bond in primary health care involves the holistic context of care. According to Terezam, Reis-Queiroz, and Hoga[15], self-awareness among professionals is important, enabling them to better understand patients' emotions and feelings, thereby establishing empathetic relationships.

Recent studies corroborate these findings. Vieira *et al.*[16] identified the bond as a key relational mechanism for care practices encompassing prevention, promotion, diagnosis, treatment, and rehabilitation, enabling the anticipation of needs and facilitating shared care. Dias *et al.*[17] further highlight that the bond directly influences adherence to treatments, positively impacting patients' health and well-being.

Likewise, interprofessional communication plays a fundamental role in fostering meaningful provider-user relationships. Strategies including interdisciplinary meetings and the integration of information technologies have been identified as effective mechanisms for strengthening collaborative practice and, consequently, enhancing users' engagement and trust[18].

Moreover, in the context of access to health information, an experience report on the development of a podcast focused on self-care in health promotion within the

Brazilian Unified Health System (SUS) highlights this tool's potential to reach populations that rarely seek health services, thereby extending the reach of care beyond the physical boundaries of primary health care units and overcoming geographical barriers. In this scenario, the function of Nursing is particularly notable, as nurse training encompasses an inherently educational function[19].

Thus, health policies and organizational practices should create conditions that facilitate strong relationships between nursing professionals and patients, including investments in continuing education, professional recognition, the improvement of working conditions, and the promotion of effective communication, particularly by accessible information technologies.

From this perspective, the act of welcoming constitutes an important tool in the development of this relationship, as the way professionals receive users and their availability to address their needs establishes a bond grounded in respect and trust. Accounts from professionals emphasize key strategies for strengthening this bond, including trust, active listening, humanized care, respect, ethical practice, knowledge of the case, and home visits – practices that are supported by recent studies.[20,21].

Nevertheless, this process faces challenges that span structural, organizational, and subjective dimensions. Limited transportation and difficulties in accessing primary health care units (PHCUs), particularly in rural areas, are recurring obstacles that compromise continuity of care and the effectiveness of interventions. These factors are widely recognized in the literature as constraining the establishment of a therapeutic bond[22]. Employment instability generates uncertainty regarding professionals' permanence in the community, and the frequent absence of users from PHCUs further impedes the consolidation of enduring relationships.

Overcoming these challenges requires integrated strategies that encompass investments in transportation, employment stability, and professional development aimed at enhancing interpersonal skills. The promotion of opportunities for active listening and supportive engagement is also essential to foster trust and mutual respect, which are fundamental to the quality of care within the Family Health Strategy (ESF).

The category "Strengthening Bonds between the Nursing Team and Users": Contributions of Community Health Agents and Institutional Partnerships" highlights the mechanisms for engaging patients who miss appointments, with particular emphasis on the active outreach conducted by Community Health Agents. This strategy plays a central role in reducing absenteeism, as Community Health Agents identify and contact absent patients, aiming to understand the reasons for their absence and encourage them to attend follow-up appointments. Morosini and Fonseca[23] point out that home visits constitute the primary activity of Community Health Agents, who monitor the health conditions of families within their coverage area, in addition to conducting active outreach.

Children's attendance at well-child visits and pregnant women's participation in prenatal care appointments enhances adherence to follow-up, improves quality of life, and strengthens the bond with the health care team, thereby promoting health and preventing disease. Moreover, Community Health Agents (ACS) serve as a bridge between the community and the Primary Health Unit (UBS), reinforcing this relationship[23,24]. Collaborations with the Guardianship Council, social services, and

educational programs, such as the Health in Schools initiative, complement these efforts, further increasing user engagement in the activities of the Family Health Strategy (ESF).

Beyond the local context examined, the findings of this study align with a national scenario in which primary health care faces common challenges, including staff turnover, precarious employment conditions, and the need to reinforce humanized and patient-centered care. These issues are not confined to the municipality under study but reflect a broader problem observed across different regions of Brazil, particularly in areas of greater social vulnerability.

The participants' statements underscore that the quality of care and the development of bonds between professionals and users constitute core pillars of the National Humanization Policy (PNH) and the effectiveness of the Family Health Strategy (ESF). Accordingly, the findings discussed here contribute to the national debate on the need for public policies that ensure greater team stability, recognition of multidisciplinary work, and investments in continuous professional development, aiming to consolidate a more resolute, accessible, and equitable model of care.

Hence, although grounded in a specific municipal context, this research carries implications that extend beyond local boundaries, providing guidance for managers, professionals, and researchers aiming to enhance reception practices and the development of bonds in primary health care across different regions of the country.

FINAL CONSIDERATIONS

This study identified the primary factors influencing the formation and reinforcement of the bond between nursing professionals and users in primary health care in the municipality of Arneiroz, Ceará. It became evident that this bond is grounded in key pillars such as active listening, humanized care, empathy, respect, and mutual trust. Strategies employed by the teams – including home visits, active outreach, and institutional partnerships, with particular emphasis on the role of Community Health Agents (ACS) – proved essential for consolidating the professional-user relationship, particularly in hard-to-reach contexts.

Conversely, the study also highlighted structural and organizational challenges that impede this process, including the poor condition of rural roads, lack of transportation to remote areas, user absenteeism at primary health care units, and contractual instability among professionals, particularly temporary staff. These factors undermine the continuity of care and the establishment of a longitudinal bond, a central component of the Family Health Strategy.

Among the study's limitations, the restricted geographic scope to a single small municipality stands out, which may limit the generalization of the findings to other realities. Furthermore, the small number of participants, while consistent with the qualitative methodological approach, does not allow for statistical expansion of the data. Even so, the results provide a deep understanding of the phenomenon studied, with a wealth of subjective and contextual information.

As a contribution to the field of nursing, this research reinforces the need to strengthen continuing health education policies, focusing on qualification for welcoming practices, promoting lasting bonds, and overcoming technocratic approaches in care. It

also highlights the importance of professional recognition and the adoption of intersectoral strategies as tools for more comprehensive care, especially in territories with greater social and geographical vulnerability.

Accordingly, the findings of this study can inform managers and primary health care professionals in developing strategies that enhance access, reinforce bonds, and foster tangible improvements in the health care process, with a view to the continuous advancement of the care provided to the population.

REFERENCES

1. Organização Pan-Americana da Saúde. A atenção à saúde coordenada pela APS: construindo as redes de atenção no SUS: contribuições para o debate. Brasília: Organização Pan-Americana da Saúde; 2011. 113 p. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/atencao_saude_coordenada_APS_construindo_redes_atencao_sus_2ed.pdf.

2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica [Internet]. Brasília: Ministério da Saúde; 2012 [citado 2024 out 9]. (Série E. Legislação em Saúde). Disponível em: https://www.gov.br/saude/pt-br/composicao/saps/esf/consultorio-na-rua/arquivos/2012/politica-nacional-de-atencao-basica-pnab.pdf.

3. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde [Internet]. 2ª ed. Brasília: Ministério da Saúde; 2010 [citado 2024 nov 30]. 44 p. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/acolhimento_praticas_producao_saude.pdf

4. Tesser CD, Neto PP, Campos GW de S. Acolhimento e desmedicalização social: um desafio para as equipes de saúde da família. Ciênc Saúde Coletiva. 2010;15(3):3515–24. Available from: https://www.redalyc.org/pdf/630/63017302036.pdf.

5. Brunello MEF, Ponce MAZ, Assis EG de, Andrade RLP, Scatena, LM, Palha, PF, Villa TCS. O vínculo na atenção à saúde: revisão sistematizada na literatura, Brasil (1998–2007). Acta Paul Enferm. 2010;23(1):131–5. Available from: https://www.scielo.br/j/ape/a/cZmxbMPbffBXzgyGtmMVMSQ/.

6. Brasil. Ministério da Saúde. Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização. HumanizaSUS: Política Nacional de Humanização: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS [Internet]. Brasília: Ministério da Saúde; 2004 [citado 2024 nov 30]. Disponível em: http://adcon.rn.gov.br/ACERVO/sesap/DOC/DOC000000000125646.PDF

7. Yamamoto AO, Duarte AG, Oliveira JLB de, Espindola TL. A importância do vínculo profissional com o usuário na atenção primária em saúde: revisão de escopo. Contribuciones a Las Ciencias Sociales. 2024;17(10):e11336. Available from: https://ojs.revistacontribuciones.com/ojs/index.php/clcs/article/view/11336.

8. De Assis BCS, de Sousa GS, da Silva GG, Pereira MO. Que fatores afetam a satisfação e sobrecarga de trabalho em unidades da atenção primária à saúde? Rev Eletr Acervo Saúde. 2020;12(6):e3134. Available from: https://acervomais.com.br/index.php/saude/article/download/3134/1882/.

9. Cunha EM da. Vínculo longitudinal na Atenção Primária: avaliando os modelos assistenciais do SUS. [tese]. Rio de Janeiro: Escola Nacional de Saúde Pública Sérgio Arouca; 2009. 150 f. Disponível em: https://www.arca.fiocruz.br/bitstream/icict/2587/1/ENSP_Tese_Cunha_Elenice_Machado.pdf.

10. Minayo MCS, organizadora. Pesquisa Social: Teoria, método e criatividade. 18. ed. Petrópolis: Vozes; 2001. Disponível em: https://www.faed.udesc.br/arquivos/id_submenu/1428/minayo__2001.pdf.
11. Brasil. Ministério da Saúde. Resolução nº 466, de 12 de dezembro de 2012b. Trata de pesquisas e testes em seres humanos. Diário Oficial da União, Brasília, DF, 13 de junho de 2013. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html.
12. Brasil. Ministério da Saúde. Resolução nº 510, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais cujos procedimentos metodológicos envolvam a utilização de dados diretamente obtidos com os participantes ou de informações identificáveis ou que possam acarretar riscos maiores do que os existentes na vida cotidiana, na forma definida nesta Resolução. Diário Oficial [da] República Federativa do Brasil, Brasília, DF, 24 mai. 2016. Disponível em: https://www.gov.br/conselho-nacional-de-saude/pt-br/atos-normativos/resolucoes/2016/resolucao-no-510.pdf
13. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Acolhimento à demanda espontânea. 1. ed.; 1. reimpr. Brasília: Ministério da Saúde; 2013. 56 p. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/acolhimento_demanda_espontanea_cab28v1.pdf.
14. Marques VGPS, Martins TM, Lima MWL, Oliveira IMR, Silva MAS, Lima WLL et al. A importância do acolhimento na atenção primária à saúde. RECISATEC – Rev Cient Saúde e Tecnol. 2022;2(7):1-7. Available from: https://recisatec.com.br/index.php/recisatec/article/view/167/137.
15. Terezam R, Reis-Queiroz J, Hoga LAK. A importância da empatia no cuidado em saúde e enfermagem. Rev Bras Enferm. 2017;70(3):697-698. Available from: https://www.scielo.br/j/reben/a/mgVBxzyYCCsDtD5VssdftWn.
16. Vieria LB, Nora CRD, Toso BRGO, Geremia, DS, Mendonça AVM, Sousa MF. O vínculo na Atenção Primária à Saúde: práticas dos enfermeiros da região Sul do Brasil. Tempus: Actas de Saúde Coletiva. 2022;16(4):121-132. Available from: https://www.tempusactas.unb.br/index.php/tempus/article/view/3042/2167.
17. Dias GMC, Teixeira ALS, Cunha CF, Araújo LB, Silva RPM, Gomes VB, et al. A importância do vínculo binômio profissional-paciente: um relato de experiência. Rev FT. 2022; [citado em 2025 abr. 10]. Available from: https://revistaft.com.br/a-importancia-do-vinculo-binomio-profissional-paciente-um-relato-de-experiencia/.
18. Castelo RAB, Fontenele NAO, Sá GGM, Neto NMG, Barros LM. Estratégias para melhora da comunicação interprofissional na Atenção Primária à Saúde: revisão integrativa. Rev Enferm Atenção Saúde. 2024;13(3):e202443. Available from: https://docs.bvsalud.org/biblioref/2025/02/1587305/15-estrategias-para-melhora-da-comunicacao-interprofissional-n_bAdYN40.pdf
19. Albuquerque MS, Vasconcelos SP, Fontineles CFF, Farias GMM, Silva CDS. Construção de podcast sobre autocuidado na promoção da saúde no SUS. Cadernos ESP. 2022;16(4):135-8. Available from: https://cadernos.esp.ce.gov.br/index.php/cadernos/article/download/942/394.
20. Lachtim SAF. Vínculo e acolhimento na Atenção Primária à Saúde: potencialidades e desafios para o cuidado. Tempus – Actas de Saúde Coletiva. 2023;16(4):3060. Available from: https://docs.bvsalud.org/biblioref/2023/04/1425820/3060-texto-do-artigo-11877-1-10-20230402.pdf.
21. Januário TGFM, Varela LD, Oliveira KNS, Faustino RS, Pinto AGA. Escuta e valorização dos usuários: concepções e práticas na gestão do cuidado na Estratégia Saúde da Família. Ciênc.

saúde colet. 2023;28(8):2283-2290. Available from: https://www.scielo.br/j/csc/a/fGPXqYvy96dM7xnSqxQpH8h/.
22. Viegas APB, Carmo RF, Luz ZMF. Fatores que influenciam o acesso aos serviços de saúde na visão de profissionais e usuários de uma unidade básica de referência. Saúde Soc. 2015;24(1):100-112. Available from: https://www.scielo.br/j/sausoc/a/J9LSP5w9SXvH5K8W6YFTLfC/?format=pdf&lang=pt.
23. Morosini MV, Fonseca AF. Os agentes comunitários na Atenção Primária à Saúde no Brasil: inventário de conquistas e desafios. Saúde debate. 2018;42(especial 1):261-274. Available from: https://www.scielo.br/j/sdeb/a/CtVJJm7MRgkGKjTRnSd9mxG/?format=pdf&lang=pt.
24. Fermino JM, Silva AT, Shirasaki RTS, Cangussu JML, Santos DA, Vargas EB, et al. Potencialidades e dificuldades nas práticas de acolhimento na rede de atenção básica conforme a Política Nacional de Humanização. Saúde Transform Soc. 2016;6(2):54-69. Available from: https://incubadora.periodicos.ufsc.br/index.php/saudeetransformacao/article/view/3313/4470.