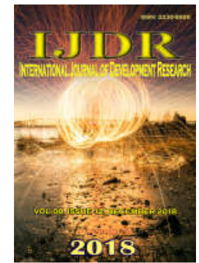
ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 08, Issue, 12, pp.24537-24541, December, 2018



ORIGINAL RESEARCH ARTICLE

OPEN ACCESS

WORKING CONDITIONS OF ORAL HEALTH TEAMS IN THE FAMILY HEALTH STRATEGY

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ARTICLE INFO

Article History:

Received 03rd September, 2018
Received in revised form
01st October, 2018
Accepted 29th November, 2018
Published online 26th December, 2018

Key Words:

Oral Health, Work conditions,
Evaluation of the oral health team,
Family Health.

ABSTRACT

The oral health team (eSB) has been expanding since the 2000s with the advent of the Family Health Strategy, and with this comes the insertion of the Dental Surgeon (CD), Auxiliary in Oral Health (ASB) and Oral Health Technician (TSB) in primary care. This review study aims to evaluate the oral health and the conditions of the teams that work in the Family Health Strategy. As an methodology, an integrative review was used to search for publications in the VHL portal. For the discussion of the results the data were organized into three categories: (1) Employment Bond and Compensation; (2) Structural factors: physical structure and inputs; (3) The organization of the work process. It was found that there was an expansion of oral health teams and improved access, however, there is still a great demand, lack of municipal management, planning and insufficient permanent education for professionals.

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Citation: GOMES, Bruna Cristiane Furtado, PULCINELLI, Felipe Melo, STRECK, Mônica Tábata Heringer, CARVALHO, Jordana Lopes and WEILLER, Teresinha Heck, 2018. "Working conditions of oral health teams in the family health strategy", *International Journal of Development Research*, 8, (12), 24537-24541.

INTRODUCTION

The Brazilian model of health care is characterized by the actions and services of health promotion, protection and recovery, being organized regionally and hierarchically. Its main gateway is Primary Health Care (PHC), which should be the originator of the care network, preferably through the Family Health Strategy (ESF) (Brazil, 2011). The ESF has demonstrated its ability to reorganize practices in PHC. It is a technological innovation in the management and organization of work, and it combines cutting-edge guidelines (Mattos *et al.,* 2014). The PHC is developed through care and management practices, democratic and participative, in the form of multidisciplinary teamwork, directed to users, with defined territories, for which it assumes the sanitary responsibility, considering the dynamics existing in the territory in which they live populations, observing criteria of risk, vulnerability, resilience and the ethical imperative that all demand, health need or suffering must be accepted (Brazil, 2011). At the global level, the dental surgeon develops his activities in a private area, but in Brazil, the insertion of this professional in the public service since 2000, with the Oral Health teams (eSB), Scherer, Carcereri, 2015). The oral health team is part of the Family Health Strategy (ESF), which is an important structural and organizational axis of the health system, being the first port of entry and access for people seeking the public health and the dental surgeon (Brazil, 2011). This strategy, coupled with the new National Curricular Guidelines (DCN) of undergraduate courses in the health area, the guidelines for the National Oral Health Policy (PNSB) and the National Primary Care Policy (PNAB) contribute to reinforce the view of dentistry for the field of Collective Oral Health (SBC) (Botazzo and Chaves, 2013). Oral health is fundamental to the quality of life of the individual and his or her family as a whole. Analyzing the working condition of the oral health teams and how they are organized is an important factor to establish priorities and strategies to increasingly improve the quality of service, generating resolution and impact actions that contribute to the promotion of oral health in the population. Several factors may interfere with the quality of oral health services in the FHT, as well as the lack of continuing education for professionals, inadequate physical space to carry out activities, the great demand of patients, the

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articulation of reference and counter-referral, the lack of articulation between the team members and the difficulty of replacing the old practices and the acceptance of the new model are the main factors that hinder and / or impede the implementation of the operational characteristics proposed by the Ministry of Health (Rocha and Araujo, 2009). Brazil has an estimated population coverage of Oral Health (eSB) teams in Primary Care (AB) of 52.18% (BRAZIL, 2018). The work of oral health teams often encounters obstacles in the public service due to the low investment in inputs, unprepared managers and inadequate physical structure, and the fact that family health work is not an attraction for the professional dental surgeon due to the low remuneration. The quality of the oral health service will only be effective when managers and municipalities are effectively concerned with the teams and invest in a quality and well structured public service. In order to achieve humanized care, it is necessary to value health professionals, because if workers are satisfied with their work, they will be able to provide humanized care to the user. However, there are few studies evaluating job satisfaction, health problems and quality of life of Oral Health workers (Moimaz *et al.,* 2015). In this sense, this review study aims to know the working conditions of professionals of the oral health team in the Family Health Strategy. Thus, based on these affirmations, the guiding questions of this work stand out: What are the scientific evidences regarding the working conditions of the Oral Health Team in the Family Health Strategy?

The relevance of this research is justified by the need to know the working conditions of oral health teams in order to think about adequate public policies that address the needs of both users and health professionals. The evaluation of the working conditions of the oral health teams is relevant considering that the results can influence professional practices, techniques and applications of resources.

MATERIALS AND METHODS

In order to reach the objective of this study, we opted for an integrative review. This type of review allows to gather and synthesize results of research on a certain topic, point out gaps in knowledge and synthesize multiple published studies. In this way, integrative reviews can directly contribute to the state of knowledge, implementation of interventions and identification of gaps that guide the development of other studies (MENDES *et al.,* 2008).

During the preparation of this study, the following steps were taken: (1) establishment of the research question; (2) selection of descriptors; (3) choice of databases; (4) definition of inclusion criteria and exclusion of studies; (5) categorization of studies; (6) analysis of the studies; interpretation of results and synthesis of knowledge (Mendes *et al.,* 2008).

The identification and selection of the studies occurred in September 2018 through the guiding question: "What are the scientific evidences related to the working conditions of the Oral Health team in the Family Health Strategy?" In order to search the publications, if the VHL portal, and the Health Sciences Descriptors (DeCS) used were "Oral Health" and "Working Conditions" using the Boolean operator OR. The inclusion criteria were: original studies published until December 2017, indexed in the VHL portal, published in the Portuguese, Spanish and English languages and available in full, free and online. As exclusion criteria will not be used, dissertations, theses and articles that do not answer the question of research. In order to minimize possible bias of the studies, two researchers performed the articles reading and filling the instrument independently, which were later compared. There were no reports on the evaluation of the publications. For the elaboration of the results and discussions, 8 articles answered the guiding question.

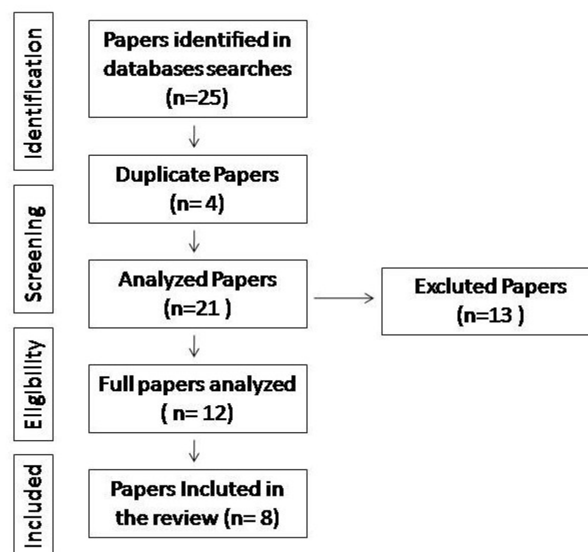

Figure 1. Selection of studies in the databases

To achieve the objectives of this study, the selected articles were analyzed, the data were categorized, interpreted and grouped according to similarity.

RESULTS

When analyzing the material collected, it can be affirmed that there are few studies addressing the working conditions of oral health teams. The largest concentration of studies developed is in the Southeast region. In this region, the first Postgraduate Programs in Epidemiology and Public Health were implemented, in addition to concentrating the largest population. During the analysis of the articles the difficulties regarding the working conditions of the oral health team were categorized according to the frequency that emerged in the studies. For the discussion of the results the data were organized into three categories: (1) Employment Bond and Compensation; (2) Structural factors: physical structure and inputs; (3) The organization of the work process.

DISCUSSION

Employment and Compensation Bond

In general, Oral Health is a service with a high financial cost, due to the need for investment in the purchase of materials, instruments and essential equipment for dental care. In a study conducted by Mattos, Ferreira, Greco, Leite (2014) managers reaffirm the difficulty of implementing the eSB due to the high maintenance cost, according to these authors from 2014 after the increase of federal financial transfers to the municipalities (2014) there was an expressive expansion of Oral Health in Brazil. The motivation for SB implantation by managers in Brazil is the possibility of changing the techno-assistance model, followed by financial incentives from the Ministry of

Table 1 - Selected studies in the databases

Autor	Objetivos	Principais Resultados
Aquilante, Aciole (2015)	To carry out a study of the process of implementation of the PNSB in the municipalities of the Regional Department of Health of Araraquara (DRS III), from the perspective of managers and oral health professionals.	Identifications of stocks, structural dissatisfaction, lack of insight and high turnover of professionals, instability in hiring and absence of wage isonomy.
Rocha, Araújo (2009)	Check the working conditions of the dentists in the oral health teams (ESBs) inserted in the Family Health Program (PSF)	It was observed inadequate physical structure, inadequate equipment and material to carry out the planned actions, the absence of articulation of the reference and counter-reference so that the needs of greater complexity are met, low qualification of the professionals for the team work.
Maciel, Santos, Rodrigues (2015)	Analyze the perceptions about the working conditions of the technical staff of the Basic Units of Health (UBS) of Fortaleza, Ceará	Working conditions are precarious both in terms of the infrastructure of the units and in relation to the organization of the tasks and activities of the technicians, and are reflected on the health of these professionals, who are physically and emotionally exhausted
Gavêas, Oliveira, Esposti, Neto, (2016)	Understand the relationship between oral health technicians and dentists at work and the factors that may favor or hinder this relationship	The conditions of work evidenced were the instability of contracts, where selective processes of temporary nature and lack of professional qualification prevail, and inadequate infrastructure and lack of inputs.
Mattos, Ferreira, Leite, Greco (2014)	To discuss the inclusion of oral health in the Family Health Strategy in cities of a micro-region of southeastern Brazil from the perspective of human resources.	There are critical nodes in the hiring and qualification of human resources to work in the oral health team and in the integration among health professionals. Access is better, either by the organization carried out or by the expansion of teams.
Reis, Scherer, Carcereri, (2015)	Understand the work of the dentist in primary care through documentary analysis, job observation and interviews.	Limitations in the availability of inputs, infrastructure and instruments, as well as in the management and organization of work, lack of training and preparation for work, lack of managerial dialogue with the Oral Health Teams, and lack of capacity and profile for work
Gonçalves, Ramos (2010)	Discuss and analyze how the daily activities of professionals in the health units of the municipality are potentializing and / or limiting the implementation of the ESF proposal in its directives andpressions	Precarious conditions of the units, compromising the biosafety of clinical care, inadequate infrastructure, lack of equipment maintenance, lack of planning and organization of actions, lack of training and management support.
Moimaz, et al, (2015)	To verify the satisfaction and the quality of life, besides the health of dentists of the public system	Lack of work organization and unhealthy physical work environment, thermal and sound discomforts, as well as pain, were the main reported complaints. Income and leisure, for the most part, are unsatisfactory.

Health and the possibility of expanding the supply of human resources trained for the population (Mattos, Ferreira, Greco, Leite, 2014). One of the greatest difficulties that have emerged in the published articles relates to the form of contracting that usually occurs by temporary contracts, and the low remunerations. The Oral Health team is usually hired by means of a selective process, legal regime CLT (Work Law Consolidation) and workload that can vary from 15 to 40 hours / week, with hiring for most common Family Health teams is through a temporary recruitment process to work 40 hours / week (Aquilante, Acioli, 2015). The studies indicate that in many municipalities there is no ASB position, being they are hired as general service aides, or appointed by the manager, often without adequate training to perform the function (Aquilante, Acioli, 2015; Mattos, Ferreira, Greco, Leite, 2014). Temporary contracts and the lack of career plans leave professionals unsecured to pursue careers in public services, and still generate the demotivation and inability to demand better working conditions due to contractual instability. According to Aquilante and Acioli (2015), the remuneration (including basic and additional salary) of dentists with a workload of 20 hours / week is R $ 2,045.87, while those of 40 hours / week have an average wage of R $ 3,350.32, similar to that found in Rocha and Araújo's study (2009). The Oral Health technicians receive R $ 1,500.00 / month, while the average salary of the ASBs is R $ 794.21, although the salary is outdated, technicians and auxiliaries admit that the remuneration in the public service is better than in private practices (Aquilante and Acioli, 2015). In the meantime, in the study of Aquilante and Aciole (2015) of the 24 municipalities evaluated in the northeastern region of São Paulo, no municipality had wage equations among higher-level health professionals and there were no career plans, careers and salaries, factors that discourage work in the public health service. Mattos, Ferreira, Greco and Leite, (2014) also presented similar data, and of the 43 dentists who participated in the study, 12 (27.91%) already worked in the city's oral health service before insertion into the eSB. 29 (67.44%) had a link with the municipality, through a temporary contract, and 28 (58.30%) were nominated to take office, while the 48 ASBs, 25 (52.08%) went through contracts and 18 (37.50%) assumed the position by criterion of political indication. The oral health team has often been transformed by political practices into job instability, especially in smaller municipalities (Mattos, Ferreira, Greco, Leite, 2014). The hiring of human resources to work in the eSB is still one of the main difficulties for the development of the care model. Precarious employment and the difficulty of full-time contracts may result in inability to work, instability of the human resource against the population and absence or high turnover of the professional. In this logic, the precariousness of work - expressed, inter alia, in the temporary contract of service, implies greater instability and insecurity for the workers, who end up not being totally attached to the service, since their permanence is short (Mattos, Ferreira, Greco, Leite, 2014 and Gonçalves, Ramos, 2010). The reflexes of this instability in the contracting of the oral health team reflect in an essential attribute of PHC, longitudinality, which is recognized by the relationship between users and professionals, and care over time. This link can be made unfeasible, when the professional does not remain in the service. Some dental surgeons recognize, in municipal management, an ally with their work; others identify a limitation and lack of support, feeling even hostile (Reis, Scherer, Carcereri, 2015). In this sense, it is necessary to invest in actions that promote intersectoriality, such as scheduling and supervising the supply of materials and supplies for collective actions, training the FHPs with regard to educational and preventive actions in oral health (Rocha and Araujo, 2009).

Structural factors: physical structure and inputs

In order for dental health teams to provide the best care, it is necessary to have resources such as materials and necessary supplies, as well as physical space and adequate infrastructure to provide care to the population, making the service effective and supportive of the needs of the citizens who and the search (Esposti *et al.,* 2012, 2009, Pucca, 2006). The Ministry of

Health has already foreseen this imperative by establishing and making available financial resources for the acquisition of at least two dental equipments (chair, focus and auxiliary unit) for the work of a modality II eSB in the ESF, composed of CD, TSB and ASB (Pucca, 2006). However, the studies show aspects related to the physical conditions and structure of the workplace (its precariousness), as well as the lack of equipment and materials, poor lighting, maintenance-free equipment, broken chairs and tables, and inadequate conditions for sterilization of instruments (Maciel, Santos, Rodrigues 2015, Aquilante, Acioli, 2015, Rocha and Araujo, 2009, Gonçalves and Ramos, 2010). Despite this, there were complaints regarding the maintenance of equipment (equipment, furniture, air-conditioning), the difficulty and delay in getting the technical assistance, and materials that would enable a better service of the population, such as electronic devices for prophylaxis. small repairs, and acquisition of materials are carried out and financed by the workers themselves. That is, when human resources are lacking, consumption materials and infrastructure are lacking (Maciel, Santos, Rodrigues, 2015, Gonçalves and Ramos 2010).

The physical space of the office is usually very limited, the quantity and quality of the materials and instruments depends on how the purchases are made and how the resources are managed (Aquilante, Acioli, 2015). Thus, Moimaz (2015) in his study identified that 61 (75%) of dental surgeons have already stopped attending patients in the SUS due to lack of working conditions, at some point in their professional practice, 23 (28%) due to lack of consumption, 53 (64%) for broken equipment, 25 (30%) for lack of water, 27 (32%) for lack of energy and 3 (4%) for other reasons, denoting evidence that SUS in some situations becomes fragile and inoperative because of the flaws in the organizational process. Factors that positively interfere in the working conditions of dentists in relation to the physical environment are the cooling of the environment by means of air conditioning, this emerged as one of the greatest needs of the professionals in the analyzed studies, as well as location and cleanliness of the workplace (Rocha, Araujo, 2009; Reis, Scherer, Caecereri, 2015, Moimaz et al 2015). The lack of air conditioners is a common complaint among professionals, and the use of ventilators in dental offices is not recommended for biosafety. Thermal discomfort in the work environment can affect professional performance, and decrease mental agility by increasing the possibility of accidents (Verdussem, 1978). However, among the factors that denote the lack of work organization and the unhealthy physical work environment, there is the sound discomfort (Moimaz *et al.,* 2015). Since occupational noise is one of the most worrying stress factors in the dental environment, due to the chronicity of its effect, besides being easily ignored by professionals, some studies have evaluated the hearing loss of dental surgeons, with time between two and five years, caused by noise, and observed that 27% of the studied sample had noise-induced hearing loss, and this value was aggravated by the increase in the working day (Souza, Mattos, 2002; Ruschel Ziembowicz, Sleifer, Mattos, 2005). Another factor that has arisen in the analyzed articles relates to the lack of safety in the work environment, the professionals are exposed to the risks related to the physical aggressions and the crimes practiced by the users as well as by people who assault the health posts, and harass professionals and users. One of the factors that contribute to this is the location of these units, which, in general, are in risk areas and do not have a security system (Maciel, Santos, Rodrigues, 2015; Reis, Scherer, Carcereri, 2015).

The organization of the work process

In the articles selected to compose the analysis corpus, the critical nodes related to the work process of the oral health team are represented by the difficulty of insertion in the multiprofessional team, the lack of an introductory course that enables the oral health team, the excess of demand, lack of resolution reference services, the difficulty of developing collective actions in health education, and the lack of permanent and continuous education. The establishment of multiprofessional teams is essential to develop the work in the logic of the FHT, resulting in integration among the team members. For dental surgeons this insertion does not happen easily, depending very much on the interest and effort of the professional himself to overcome the "isolation" of the profession (Moimaz *et al.,* 2015). The training process of the Oral Health Teams should begin concurrently with the beginning of the FHS work through the introductory course for the whole team (Brazil, 2006b). However, in the studies analyzed there was consensus about the lack of training and preparation for work in PHC, since the work does not correspond to the one recommended by oral health policies, and that innovations in the work of the oral health team are due to the level of commitment of each professional. (Reis, Scherer, Carcereri, 2015, Moimaz *et al.,* 2015).

In order for team professionals to feel motivated to carry out their work, managers must invest and qualify the service in FHSs. Thus, management must ensure stability through competitions, enabling professionals to carry out their work with motivation, commitment and tranquility (Reis, Scherer, Carcereri, 2015). The Family Health Strategy has become, in recent years, the most important proposal for a change in the health care model in Brazil, with the main objective of reorganizing the practice in Primary Care, incorporating health surveillance proposals, seeking to contemplate the principle of integrality (Mattos, Ferreira, Greco, Leite, 2014). The user's access to the Family Health Units is given by emergency care, actions are focused on curative practice and not on prevention (Aquilante, Acioli, 2015). There is a predominance of individual curative and preventive activities, in detriment of collective health promotion actions due to the great repressed demand, the collection of procedures and technical and clinical training (Aquilante, Acioli, Reer, Scherer, Carcereri, 2015). Excessive demand is one of the main factors reported by oral health technicians and auxiliaries, which endangers the quality of care provided by the population, which is a bigger problem when compared to the human, structural and physical factors available for the service in the unit of health (Maciel, Santos, Rodrigues, 2015). Aspects such as articulation of the reference and against reference that refers to directing and guiding users with more complex problems to other levels of specialization, ensuring their return and follow-up, including for purposes of complementing treatment, have not worked as expected, both for not attending the specialties and for the lack of specialists in the UBSs (Rocha, Araujo, 2009, Gonçalves and Ramos, 2010, Moimaz *et al.,* 2015). A factor that depends totally on the municipal management, identified in the studies, was the lack of a specialized service that is easy to access and resolves and that, in response to the demand, the integrality of the care provided to the population is no longer practiced by dentists and, thus, families do not have their needs and expectations

met. In relation to educational activities towards the community, the insertion of professionals in group activities, home visits and everything that is sent out of the office, activities foreseen in the attributions of dental surgeons in the ESF, still cause strangeness and distrust (Moimaz *et al.,* 2015). Scientific evidence indicates that educational activities are not carried out by professionals in detriment of the physical structure inadequate to the activities, the unavailability of equipment, instruments and materials adequate to carry out all the actions foreseen, lack of activity planning that takes into account the needs and expectations of the population, lack of professional qualification for teamwork and to carry out collective activities (Rocha, Araujo, 2009). Collaboration and good relationships at work require a favorable organizational setting. These organizational determinants include administrative support, resources for the team, open communication and mechanisms for democratic coordination, Inter professional cooperation, valorization of equal participation of all in the work processes and freedom of expression, so that they can speak of their difficulties and needs (San Martin-Rodriguez *et al.,* 2005). In this perspective, the factors that contribute the most to the oral health actions in the FHS are operational standards foreseen by the MS, are the Link with families, teamwork, delimitation of the area of action, multiprofessional approach, education and the humanization of care (Rocha, Araujo, 2009). The approach of the ESF to the work of the dentist perpasses the clinical work, since it is a logic of thinking about health in an integral and extended way. However, the academic training of professionals does not contemplate these issues, or partially contemplates, repercussions on the lack of preparation for teamwork, the interdisciplinary look and the experience of the health promotion paradigm (MATTOS, FERREIRA, GRECO, LEITE, 2014). Thus it is necessary that managers invest in permanent education for the oral health teams, favoring the change of practices.

Conclusion

In view of the results presented, it can be inferred that there was an expansion of oral health teams and improved access. However, there is still a great repressed demand, lack of municipal management, planning and permanent education. Low wages, lack of career plans and temporary contracts are not attractive to professional dental surgeons, and still influence the continuity of care and the professional's bond with the population. Lack of work organization and inadequate physical environment, maintenance of equipment, supplies for attendance, refrigeration, and inadequate physical space are the main difficulties encountered in the studies. In view of the findings of this review study, it is suggested that the municipalities' management invest in the quality and working conditions of the oral health teams, seeking to make the necessary adjustments so that the professionals perform their functions in an organized way, and that they seek the effective of the dental surgeon as a health promoter for the population.

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