ABSTRACT

**Objective:** to identify its effectiveness in terms of the extension of coverage with respect to the socioeconomic characteristics of the targeted population of Family Health Strategy; and to identify characteristics of the organization to improve the strategy, with an emphasis on the health problems of families in vulnerable socioeconomic situations. **Method:** was made an argumentative dialog with an evidence of the literature about strategies to improve the Family Health Strategy and official documents of Ministry of Health. This fact focuses in the emphasis on the main health problems of families in vulnerable socioenvironmental situations. **Results:** the Family Health Strategy is an innovative proposal supported by the principles of universality, integrity and equity to formulate new health practices and the developmental potential of community groups, with multidisciplinary teams being deployed to various regions of the country. Several studies have monitored the effectiveness of the Family Health Strategy in terms of expanding the coverage and resolution of its actions. **Conclusion:** It is recommended that future studies assess the participation of community groups as a strategy for strengthening the Family Health Strategy principles. **Descriptors:** health policy; family health; vulnerability; family.

RESUMO

**Objetivo:** identificar a efetividade, em termos de expansão de cobertura, no que diz respeito a características socioambientais da população-alvo da Estratégia Saúde da Família; e identificar as características organizacionais de melhoria da estratégia, com ênfase nos problemas de saúde de famílias em situação de vulnerabilidade socioambiental. **Método:** foi realizado um diálogo argumentativo com evidências da literatura sobre alternativas de melhora da Estratégia Saúde da Família e por meio de documentos oficiais do Ministério da Saúde. Este fato se concentra sobre os principais problemas de saúde das famílias em situação de vulnerabilidade socioambiental. **Resultados:** a Estratégia Saúde da Família é uma proposta inovadora, apoiada pelos princípios da universalidade, integralidade e equidade, para formular novas práticas em saúde e potencial de desenvolvimento de grupos comunitários, com equipes multidisciplinares que estão sendo implantadas em diferentes regiões do país. Vários estudos têm monitorado a eficácia da Estratégia Saúde da Família em termos de expansão de cobertura e resolução de suas ações. **Conclusão:** recomenda-se que estudos futuros avaliem a participação de grupos comunitários como estratégia para o fortalecimento dos princípios da Saúde da Família. **Descritores:** política de saúde; saúde da família; vulnerabilidade; família.
INTRODUCTION

The large number of Brazilian families living in conditions of socio-environmental vulnerability led the Ministry of Health (MH) to restructure the model of Primary Health Care (PHC) in 1994, creating the Family Health Strategy (FHE) to reduce inequalities in access to health services and respond in an equitable manner to the needs of the population. Families can be considered to be living in vulnerable socioenvironmental conditions when they have a high degree of deprivation (social vulnerability) or live in areas of risk or environmental deterioration (environmental vulnerability), regardless of whether these are urban or rural areas. These families have few resources to face the many challenges that exist in a country of continental proportions, such as Brazil, in which there are wide regional economic, political and social disparities. The vast majority of these families live in precarious homes in areas with low real estate values such as hillsides or near landfills, where there is poor sewer line coverage or a high risk of landslides, floods and numerous nutritional and health problems.

The socioenvironmental vulnerability of these families is the result of an accumulation of risks from various sources. These risks are not uniformly distributed across the country, and they represent a severe disadvantage for this population. Situations that arise due to poverty and social deprivation include unemployment, declining incomes and decreases in the quality of nutrition. They range from family conflicts and break-ups to environmental challenges such as droughts in the northeast and storms and floods in the southeast. These factors affect the livelihood of families by reducing employment opportunities, triggering an increase in the price of food and, consequently, worsening health and life expectancy indicators such as malnutrition and infant mortality, tuberculosis, hepatitis, dengue, leptospirosis, leprosy, diabetes, hypertension and violence among families and in urban neighborhoods.

According to the Human Development Report (2007-2008), the 2.6 million people living on less than two dollars a day (40% of the world’s population) are more vulnerable because they have fewer resources to cope with the risks to which they are constantly exposed. In Brazil, approximately 30% of the population lives in poverty and relies almost exclusively on social programs and public health services. However, although healthcare is a right guaranteed in the Brazilian constitution since 1988, services are not always sufficiently organized to welcome and respond well to the needs of families. These services depend on the combination of human resources, a physical infrastructure, administrative and financial management and the quality of care of the staff. In addition, the population's access to these services is often limited, especially in rural areas where families live far from clinics and displacement is difficult, as well as in urban clusters where services cannot meet either the high qualitative or quantitative demands. These factors reduce people's ability to deal with the situations of risk to which they are exposed.

In this context, the FHE was implemented with the aim of reducing inequalities in access to health services and responding in an equitable manner to the needs of the population. Sixteen years after its implementation, the FHE has been the subject of ongoing reviews and evaluations to monitor the process of consolidation along with its effectiveness.

This study performs a comprehensive analysis of the FHE with the following objectives: (1) to identify its effectiveness in terms of the extension of coverage with respect to the socioenvironmental characteristics of the targeted population; (2) and to identify characteristics of the organization to improve the strategy, with an emphasis on the health problems of families in vulnerable socioenvironmental situations.

First, there is a description of the FHE, focusing on its supporting principles, purpose and areas of priority. Next, the objectives of this study are determined based on the secondary data obtained from the Primary Care Information System (PCIS), which was made available by the MH, on the number of established FHE teams in the country and the estimated population coverage. This exhibition was made through a argumentative dialog with a evidence of the literature about strategies to improve the FHE and official documents of MH. This fact focuses in the emphasis on the main health problems of families in vulnerable socioenvironments.

- Family Health Strategy: organizational and doctrinal principles

To break with the model of care focused on the individual and disease, the MH created the FHE in 1994. This program supported the principles of universality, fairness and comprehensive care and the concept of the
human being as a natural and integral part of a broader context that includes family and community. \textsuperscript{1-4}

The principle of universality establishes access to actions and services for all people in the national territory, regardless of gender, race, income, occupation or other social or personal characteristics. The principle of equity calls for equal health care for the entire population, without prejudice or privileges of any kind. The principle of comprehensive care considers a person's uniqueness in addition to his/her socioenvironmental context. \textsuperscript{15-17}

The FHE aims to increase the population's access to health services, improve the quality of primary care \textsuperscript{13} by redirecting the health care model that previously focused exclusively on disease and promote healthy practices and the prevention of disease and injuries in a continuous and integrated manner.

The organizational structure of the FHE involves three government agencies (federal, state and municipal), but operationally it works more closely at the municipal level by prioritizing observation, the prevention of diseases and disorders, the promotion of health and intervention in situations that could endanger the health of individuals, families and communities. \textsuperscript{15-17}

The strategic areas of action for the FHE across the country include the elimination of leprosy and child malnutrition; the control of hypertension, tuberculosis and diabetes mellitus; a focus on the health of children, women and the elderly; and oral and overall health promotion. Other areas are defined according to regional and local priorities. \textsuperscript{4,17}

In summary, the FHE has the following purposes: a) to provide continual and universal access to quality health care by acting as the preferred gateway to the health system, which allows for the planning and decentralization of the programming of practices/actions and is in line with the principle of equity; b) to make comprehensive care for families more effective by linking actions to promote health, injury prevention, health surveillance, treatment and rehabilitation by an interdisciplinary team; c) to develop relationships and accountability among the teams and the treated population by ensuring the continuity of actions/care; d) to enrich health care professionals through encouragement and the constant monitoring of their training and qualifications; e) to evaluate and systematically monitor the results achieved as part of the planning and programming process; and f) to encourage popular participation and social control. \textsuperscript{16-17}

The FHE is, therefore, a program based on monitoring, prevention and the promotion of health that is developed through the work of multidisciplinary teams that consist of a general practitioner, one nurse, one nurse's assistant and six community health agents. Since 2000, the team has expanded in some regions to include a dentist, a dental assistant and a dental hygienist. Each team is responsible for monitoring approximately 3,000 to 4,000 people or 1,000 households in a given geographical area. The social and medical records of these people and households are registered and monitored to allow for the identification of health and illness and for the planning of the work to be performed. \textsuperscript{15-17}

In Brazil, as in other countries, the FHE teams are composed not only of trained health professionals, but also of people who reside in the community where families are treated. They are the Community Health Agents (CHA)\textsuperscript{4}, whose primary function is to forge a link between the community and the health system because they share the same territory and better understand the needs of the population. \textsuperscript{18} Currently, there are 231.4 thousand active CHA's in the country, divided into teams that are based both in rural communities and large cities. \textsuperscript{16-17}

The work of FHE teams is mainly performed in the Basic Health Units (BHU)\textsuperscript{4}, the homes of families and the community. It is focused directly on the situations of risk to which the population is exposed, and it prioritizes educational activities and promotes health, prevention and the recovery from illness and injuries, all from an integrative perspective. These teams typically operate in a defined territory with a population and focus on establishing links and creating bonds of commitment and shared responsibility between health professionals and the public. \textsuperscript{1,4,16,19}

The FHE is established primarily in areas of greater socioenvironmental vulnerability, and the services are focused on the poorest families in social and economic terms. With these families, the FHE specifically seeks to expand access to health services, encourage mass participation and respect the values, attitudes and beliefs of the population. Thus, the FHE brings a new dynamic to the structure of health services as well as to the relationship between the community and different levels of care.
• Extension of the coverage of the Family Health Program

According to official data from the MH,20,21 there has been a significant increase in the population covered by the FHE.7,22 In 2001, Brazil had an estimated population of 172,385,826 inhabitants living in 5,561 municipalities. The FHE was staffed by 13,200 teams in 3,684 (66.2%) municipalities, covering a population of 45.4 million (26.3%). Currently, in 2011, 32,000 teams are established in 5,284 municipalities to attend to a population of 101.3 million inhabitants, which represents 52.65% of the total population (192,376,496 people).

Table 1 shows the evolution of the FHE expansion from December 2001 to August 2011. The estimate of the population covered by the FHE teams is calculated by the Brazilian Institute of Geography and Statistics (IBGE), and the last census of the country was in 2010.

Table 1. Evolution of the FHE expansion in Brazil from 2001-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Established Teams (x 1,000)</th>
<th>Estimate of the Population Covered (x1,000,000)</th>
<th>Estimate of the Proportion of the population coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>13.2</td>
<td>45.4</td>
<td>26.33</td>
</tr>
<tr>
<td>2002</td>
<td>16.7</td>
<td>54.9</td>
<td>31.43</td>
</tr>
<tr>
<td>2003</td>
<td>19.1</td>
<td>59.7</td>
<td>33.75</td>
</tr>
<tr>
<td>2004</td>
<td>21.2</td>
<td>69.1</td>
<td>38.05</td>
</tr>
<tr>
<td>2005</td>
<td>24.6</td>
<td>78.6</td>
<td>42.67</td>
</tr>
<tr>
<td>2006</td>
<td>26.7</td>
<td>85.7</td>
<td>45.88</td>
</tr>
<tr>
<td>2007</td>
<td>27.3</td>
<td>87.7</td>
<td>47.65</td>
</tr>
<tr>
<td>2008</td>
<td>29.3</td>
<td>93.2</td>
<td>49.15</td>
</tr>
<tr>
<td>2009</td>
<td>30.3</td>
<td>96.1</td>
<td>50.18</td>
</tr>
<tr>
<td>2010</td>
<td>31.6</td>
<td>100.1</td>
<td>53.00</td>
</tr>
<tr>
<td>2011</td>
<td>32.0</td>
<td>101.3</td>
<td>52.65</td>
</tr>
</tbody>
</table>

Source: Ministry of Health - Primary Care Department.

In all five geographical regions of the country, the addition of municipalities to the FHE grew steadily from 2001 to 2008. In 2001, the Northern Region (with a population of 13,245,084) had 914 teams established in 274 (61.0%) municipalities, covering 3,089,017 (23.3%) inhabitants. In 2008, the total population was 15,591,792, and 2,238 teams were established in 425 municipalities, covering a population of 12,377,622 inhabitants, representing 16.8% of the total estimated population of 73,470,763 inhabitants for that year. In 2008, 8,919 teams established in 1,485 municipalities (89.0%) provided coverage to an estimated population of 29,404,802 inhabitants, representing 36.9% of the total number of 79,633,696 inhabitants.

In 2001, the Southern region had an estimated population of 25,453,264 inhabitants. Of these, 6,150,820 (24.2%) were covered by 1,881 teams established in 679 (57.1%) municipalities. In 2008, the population was 27,357,275, and 13,092,912 (47.9%) were covered by 4,115 teams established in 1,086 (91.4%) municipalities.20,1

In 2001, the Midwest region had 11,885,529 inhabitants distributed in a total of 463 municipalities. Of this total, 376 municipalities (81.2%) had 1,183 FHE teams established to cover a population of 3,923,863 (33.0%). In 2008 (with a total population of 13,501,615), 2,010 teams were distributed in 462 (99.1%) municipalities, covering a population of 6,503,930 (48.2%) inhabitants.20,1

This data set shows that access is an important indicator of the impact of primary health care, in particular for the FHE in Brazil. It is essential to monitor the results as an important tool for improving the Unified Health System (UHS).22 Access to health services is based on the relationship between the health needs of the population and the efficiency and effectiveness of the available services, which depend on reliable data on the health problems of the population to improve their performance.14,23

Thus, the FHE produces a continuous flow of interactions to produce the necessary skills

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for the problems identified in the socioenvironmental spectrum, which will in turn benefit patients, families and communities.

**Strategies for Improving the FHE Teams and Work Organization**

Typically, the FHE teams are embedded in the same community in which the treated families reside. They are interdisciplinary in nature, consisting of a relatively small number of professionals who consistently work in the same BHU. These features allow the professionals to better understand the needs of the families in their geographic jurisdiction and to more objectively assess the socioenvironmental conditions of the community as well as the beliefs and values that determine families' choices and the ways in which they relate to health services.

The integration of teams into the community favors the expansion of household access to health services in that it can detect vulnerable groups and actively search for those who are on the margins of health services. Reducing the infant mortality rate is one example as it is directly related to improvement in the quality of primary care and the expansion of the FHE. A number of studies indicated that the expansion of the FHE is associated with lower post neonatal mortality. This is associated to FHE clients regularly receive health education about breast feeding, use of oral rehydration therapy, immunization, and infant growth monitoring.

In fact, as the coverage of the FHE increased by 10%, the infant mortality rate fell by 4.6%. According to this trend, in 2012, the expected index is 14.4 deaths per thousand live births (as opposed to 43.2 in 1990), which fulfills the pact of the Millennium Goals signed by the member states of the United Nations. The teams identify that the demand exists, monitor the pregnancy and, when necessary, make referrals for more complex services.

Reproductive health of women is another matter of concern in FHE. This health system is an important and effective strategy to delivery prevention and health care services for women, including providing early and relatively destigmatized access to reproductive health services to this population. However, a limitation is that the FHE does not cover also the health of man.

Furthermore, with the expansion of the FHE, access to the identification, diagnosis and treatment of patients with tuberculosis (TB) has increased in the Primary Care Network. TB, according to the WHO report of 2008, is a global emergency. Brazil registered 94,000 new cases of TB in 2006, occupying the 16th place among the 22 countries with the highest reported TB infection rates in the world. The success rate of treatment is 77%, and the rate of noncompliance is approximately 9%. It is important to note that in this context, the Directly Observed Treatment, Short-Course (DOTS) is one strategy recommended by the WHO for achieving TB control, and supervised treatment (ST) is one of its components. According to the WHO and the MH, the coverage of DOTS in Brazil has increased since its implementation. This is mainly due to the decentralization of the actions to control TB to the Primary Health Care Network in municipalities, predominantly by the FHE. In 2007, there was a decrease in the percentage of coverage. This reduction, however, was not related to the number of health centers that provided supervised treatment in the country, but rather it was due to the increased number of reporting units.

Other studies strengthen the evidence that in Brazil the treatment is easy as decentralization of the Tuberculosis Control Program is taking place, with the progressive transfer of activities from ‘tuberculosis health units’ to health units in the FHE. This situation favors the TB patients who live in the community assisted by the FHE, because patients that not living in an area that receives visits by the FHE teams, increased the risk of relapse treatment significantly than among patients living in areas where the FHE was implemented.

Beyond that, another communicable disease worked in literature is Hansen’s disease, or leprosy. In this case, patients with the disease are frequently visited by CHA and involve entire families in working toward the health maintenance or treatment of its members. This activity makes the FHE one promising means of ensuring adherence to treatment. If the family is working together on health issues and if FHE representatives are understood as promoters of general health by the community, the potential for stigma associated with house visits is greatly reduced or eliminated.

This expansion is directly related to the characteristics of the team’s closeness to the families and to the active search of households conducted by the team, such that confidence in the team may promote greater compliance by the patients. This is
extremely important as the incidence of TB is higher among poor families, many of which have a high degree of socioenvironmental risk and have many people sharing the same physical space.38

Thus, the FHE is a political and structural strategy that is capable of assisting in the resolution to detect a higher number of cases through the completion of patient screenings. It also leads to family involvement in controlling the spread of the disease both within the home and outside the home in places the patients frequent, such as at work, at school and in the neighborhood.

Another advancement directly related to the working characteristics of the organization is the compliance to care provided by the FHE to families in socioenvironmental vulnerable situations who, in general, do not feel welcome at large institutions with rotating teams, such as those found at hospitals and clinics. One example is the monitoring of chronic non-transmissible diseases, particularly among the elderly, who feel accepting and confident when the monitoring is carried out by the same team in the clinic and at home.39 40 For example, hypertension is a risk factor for coronary disease, cerebrovascular disease, peripheral vascular disease, heart failure and end-stage renal disease. These illnesses are significant causes of morbidity and mortality, with high social costs.41 There is some evidence to suggest the potentially significant influence of the FHE teams (established in different locations in Brazil) on this aspect of public health, and this is independent of influences that certain demographic characteristics may have on hypertension control.42

The potentially significant influence of the FHE can be seen on the reduction of ambulatory care sensitive hospitalizations in Brazil. Expansions of the FHE were associated with reductions in hospitalizations for diabetes mellitus, respiratory problems, and circulatory conditions hospitalizations.31

● Attention and Family Bonding by the FHE

It is important to note that compliance to the treatment prescribed by the FHE is assured by the attention that the team provides to families to promote their integration into the service and to develop a type of care that addresses other health services in the community, while maintaining continuous, problem-solving assistance.6,17

This attention encourages bonding between the professional health team and the families in a given territory, which then enables them to create a relationship of commitment and shared responsibility. This bond influences the type of care and promotes the acceptance and compliance of the community toward the work performed by the family health team.14,43

In order to further elucidate the role of bonding, CHA’ work puts into practice the Brazilian concept of ‘integration’ in FHE. A recent study about the effectiveness of CHA actions in situation of social vulnerability indicated this worker as a social actor, who provides accurate and detailed community diagnoses. All of which account for their positive impact on actions and interventions by the FHE team. They become catalysts to mobilize people, inspire hope and design avenues for action. In working to enforce the human rights of their clients and communities. CHA’s may provoke changes beyond the role they envisioned for themselves and move communities from fatalism toward empowerment.18 A example of bonding in FHE is the attempt to provide long-term care for older people by the home-based. The older people’s families depend on institutional networks for their health maintenance.40,44

The attention and bonding provide a unique opportunity for the FHE team to understand the micro-family context and to become aware of the processes that take place at this level. These two elements are intrinsic to a family health policy that enables a relationship between families and professionals that can promote trust and safety, which are fundamental for the compliance of families to the FHE. The proximity of the established community and the attention and bonding of the team and impoverished families makes it possible to prevent and monitor situations of risk in an environment that may positively or negatively influence a person’s health.45 Finally, the attention and bonding in the context of the FHE forms a two-way street; in other words, the professional tends to the family through health services and the family tends to the privacy of their everyday life, which enhances the mutual bond.

● Community Participation in Social Control

The continued participation of the society in public management is a right guaranteed in the Federal Constitution of Brazil,11,46 and it allows all citizens to participate in the formation of public policies and to carry out
continued surveillance on the application of financial resources used by the State.

This constitutional right purports the principle of social control, whose objective is to expand and increase popular participation with the State on health issues to establish a service focused on local needs by promoting better compliance to their actions.

The FHE, in its organizational structure, constitutes a strategy for promoting opportunities to participate in social control through the development of collective alliances of shared responsibility between the communities and professionals on the health care teams.

Among the mechanisms for citizen participation in the formation of public health policies in Brazil is the Health Councils (CH), which exist at the federal, state, municipal and community levels. In particular, the community health councils directly linked to the existence of the FHE are called Local Health Councils (LHC) and consist of representatives from local communities along with FHE health professionals.

The LHCs have, among other functions that are specific to municipal ordinances, the tasks of investing in, producing and delivering health services, evaluating health policies and setting priorities for health actions to be executed by the FHE in their coverage area. The alliances of shared responsibility between the team and the community enable a relationship of trust to be built and empower consensus decision-making and planning along with the resolution of the socioenvironmental problems that exist in the communities where the FHE is established. Prior studies have shown that the participation in the FHE suggests decreases barriers to access and this was associated with improved immunization rates, breast feeding rates, maternal management of diarrhea and respiratory infections and implementation of preventive programs, for example, against hypertension and diabetes.

We should note that the organizational structure of the FHE is a socioenvironmental strategy in the PHC field that not only generates access to practices for the prevention, treatment and rehabilitation of illness and injury and the promotion of general health, but also generates access to opportunities and develops personal skills from collective achievement because it encourages the development of collective spaces for participation in social control.

The operational structure of the FHE therefore allows the teams to work to ensure access to processes that promote the socioenvironmental health of families and communities. The structure creates a closer relationship between public agencies and community groups in defining the intersecting actions that represent an integrated, effective and decisive action against the conditions of socioenvironmental vulnerability in the communities under the jurisdiction of the FHE. Thus, the participation of families and community groups in social control is possible, and this participation promotes inclusion, bonding and compliance and contributes to the viability of the FHE in the Brazilian UHS.

● The Principle of Integrality in the Promotion of Family and Socioenvironmental Health

As one of the principles of the FHE, integrality can be understood from three perspectives. The first is how to guide professional practices associated with the attitude of professionals, and this is typically linked to the notion of good practice. The second is how the organizing principles of working with various disciplines (which are geared to deliver types of service that include actions for the promotion of health, disease prevention, treatment and rehabilitation) can ensure a local focus, with repercussions on the health and quality of life of households. The third is how to direct governmental responses to the health problems of a population through the creation of public policies that guide the development of health programs and guidelines for organizing services.

In terms of the FHE, all three methods of understanding the principle of integrality can be used. The first establishes a contraposition to the fragmented practical model that dissociates not only the biological, social and subjective dimensions, but also the individual, the family and its history. The second creates the structural conditions in the context of PHC, such that teams with the previously described features are able to reorient their practices to integrate families and social groups into planning actions that engage the people in a community setting. The third shows the very structure of the FHE as established in the UHS which functions as the mechanism that directs professional practices and organizes services.

According to the recommendations of the MH, attention to family health should be regionalized, multi-disciplinary,
comprehensive and integrative and should take into account the emotional, social and cultural needs of families in addition to the characteristics of the environment in which they live. The families that live together in the same community form a collective unit. However, these families, although part of a collective, have distinct, similar, or identical needs, thus forming uneven groups that must be understood by the FHE. These recommendations lend support to the reorientation of the practice needed to promote family health within the structure of the FHE.

Therefore, it is important to consider that, for example, Brazilian families in recent decades have been undergoing a process of profound transformation as a result of intense social and cultural changes that modify the organizational patterns and relationships both within and outside the family unit. In addition, we must understand how this process affects the gender component, i.e., the role of females in Brazilian families, which leads to a standard among PSF communities. In general, professionals have the most contact with women when attending to families. Women are also directly linked to health services. For various reasons, the father may not be present: due to high rates of women as the head of households (at around 48% in some regions of Brazil) because he may not feel welcome in the health care system, or because he cannot miss work and risk endangering his employment as unemployment has reached high levels (up to 40% in some regions).

Within this context, discussions of involvement in the promotion of family and socioenvironmental health include identifying ways to integrate the entire family and its components into the planning of care, without increasing the occurrence of significant losses, such as the loss of a husband/partner’s job due to the need for care and limited hours of operation of the FHE. This is not a challenge if the FHE team commonly makes home visits at times when the family is reunited.

On the other hand, it also implies the commitment of professionals to create opportunities for families to learn about their own life context and to feel capable of, and responsible for, making the choices they must make, where these decisions often conflict with their values, dreams and plans. From this perspective, intervention should focus on the positive interactions between families and professionals, despite the challenges these professionals face due to the vulnerable socioenvironmental conditions in which the majority of these families live.

The goal is not to deny the difficulties, risks, and losses, but to emphasize the family potential in the community environment. Similarly, it is important to recognize that the capacity of these families can be developed or enhanced through actions taken in both the professional and non-professional environments. This implies that recognizing the ability to achieve this purpose lies not only with professionals, but also with families and informal social support networks. It further implies the importance of promoting integrative activities between healthcare organizations and the local environment (community). This is accomplished by the acceptance of the team in the community in which the FHE is established, where this acceptance is a process that is defined by the beliefs, values and knowledge of each of the communities and each of the families.

**CONCLUSION**

The FHE broadened population access to PHC services in urban and rural areas of Brazil. Characteristics of the team in the expansion of access were highlighted especially in areas with greater socioenvironmental vulnerabilities. The FHE’s insertion in the community and its proximity with the families enabled the acquisition of profound knowledge of the population’s needs. This knowledge influenced the training of professionals and the organization of services, resulting in the improvement of the FHE itself, taking into account particular characteristics of each region.

The restructuring of the PHC model, which was the goal of FHE implementation, was not fully accomplished. This restructuring depends on the FHE administration at the federal, state, and municipal levels; investment in professional training that focuses on the characteristics of the integrative health promotion model with social-environmental characteristics of the community and the population; and the prioritization of financial resources for primary care. It is possible that other factors, such as the individual and disease-centered culture, interfere with the restructuring of this model. It is recommended that future studies assess the participation of community groups as a strategy for strengthening the FHE principles.

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