

The challenge of rendering sanitary surveillance actions operational in health promotion and in the Family Health *locus*

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ABSTRACT

This article proposes an articulation between the Family Health and the Sanitary Surveillance fields of action. It reflects on how essential concepts and guidelines of the Brazilian public health system (SUS), such as integrality, social control and health promotion, can be integrated into the practice of health professionals. Family Health is both a strategy for taking on a new practice and a field leading to comprehensiveness and health promotion, in addition to being conducive to community participation. Health promotion guides a practice which can potentially transform the field of health. Sanitary Surveillance acknowledges its connection to health promotion and its ideological affinity to the principles contained in the Ottawa Letter. In view of the complex social environment in which professional and user meet, and of the hurdles to more effective health practices, training and enabling human resources becomes a tool for transforming and enhancing public health.

Key words: Sanitary surveillance. Family Health Program. Health promotion. Health human resource training.

Introduction

This paper aims to discuss the main challenges to the qualification of sanitary surveillance actions, based on a family health practice approach, starting with the health promotion logic. In this context appears the critical reflection on the possible creation of a space for critical reflection on sanitary surveillance, since several actions, such as interventions on environmental and work risks, and monitoring of quality of services, will be more effective with the improvement of social control, equally important for the family health.

For a new work process, the co-responsibilization of both the health team and the target population has been pointed out, aiming at the social construction of health demands and needs, expressed, among others, in the reorganization of practices to overcome primarily assistance practices, in the sense of health promotion actions, formally established in Ottawa (Brazil, 2001a).

In this sense, health promotion is understood as a cross-sectional articulation strategy, where visibility is bestowed to risk factors/situations, to different social groups and to differences among needs, territories and cultures of our country, aiming to establish mechanisms to reduce vulnerable situations, incorporate social control and participation in public policies management, and to defend equity. With this comprehension of the range of health interventions, where health problems and needs are articulated with their determinants, health promotion approaches the field of health surveillances. The expression “health surveillances” is in the plural form, since we recognize the existence of the epidemiological, environmental, sanitary and worker’s health surveillances, and that these have distinct configurations within the Unified Health System (SUS), and different performances as well.

The notion of health social production is the function and primary objective, without which there is no new work process; it depends on a political guidance that supports the incorporation of society in the analysis of the health-disease process and of values that professionals assume as rules for their practice. Based on a knowledge nucleus (the specific knowledge of each profession), the health practice field would be a space of imprecise limits, where each professional would search for support of another professional to carry out his own work (Campos, 2000).

The World Health Organization - WHO (OMS, 1997) recommended the health promotion strategy as methodology to develop comprehensive actions that encourage changes in life style and in environmental, economic and social conditions which determine health, transforming the attention model; so it was considered guideline to achieve “Health for all in the 21th century” (HFA/21th century), reiterating the politics “HFA/2000” for the new century. Simultaneously, the conceptual renewal of Public Health places the issue of essential functions - understood as performance of a specific and functional part of the health system - as directly addressed to actions of the whole society, social practices that comprise the broad field of conditioning and determining biological and social factors, and of its specific healthcare (Pan American Health Organization – OPS, 2002).

Health promotion is thus considered one of the main functions of public health and, as strategy articulated with other policies and technologies developed at SUS, it makes it possible to think and operate actions to meet social health needs, addressed to fellows and community.

Within this perspective, health promotion can be understood as: level of care with actions that promotes (in the sense of improving) health of non sick fellows; holistic approach of the health-disease process and of interventive ways (changes in the way of understanding and acting in health care); basic function of public health, aiming at community actions that comprise, through active citizen’s participation, inter-sectorial strengthening and empowerment to facilitate health culture (Buss, 2005). According to this author, the Family Health Program (FHP) is concerned with health promotion, whose object is population (independently of its health conditions), and whose practice comprises broad promotion, prevention, assistance and health recovering actions. The concept of empowerment has become important in the last years, and in the field of public health it has been used as strategy to gain health. Authors as Bernstein et al. (1994), Wallerstein & Bernstein (1994), and Thursz (1993 *apud* Teixeira, 2000) define empowerment as people’s ability to better understand and to control their personal, social, economic and political strength, acting to improve their living conditions.

Within the idea of health promotion, this concept is an important resource to sustain health education actions, both individually and collectively oriented in social groups and organizations, through participative educational processes. So it will try to articulate technical and popular knowledge, and to mobilize institutional, community, public and private resources, in order to face and to solve health problems and their determinants (Buss, 2000).

Again, health promotion is regarded as possibility to comprehend the role of social determinants in health and in sickness, such as unemployment, starvation, difficult access to education, inadequate residences, among others, shifting the traditional focus on living manners, in a fragmented and individual perspective, to place it in the perspective of collective construction and in the context of the fellows' own lives and communities. Conversely, it fosters the articulation of different types of knowledge, recognizing the several agents and power relations, analyzing the answers given by services for health demands.

Concerning politics, there are movements to qualify practices and strengthen social control, such as the Humanized SUS (Brazil, 2003), user's handbook (Brazil, 2006a) and social control at the SUS³. Humanization presupposes professional capacitation, social control and an operational preoccupation with the reorganization of services and practices. It is through dialogue and communication that humanization becomes possible and solidarity opens a perspective for humanization. In this sense, humanization of health care implies both listening to the user and to the health professional, so as they can be part of a dialogic network, in which health actions are conceived based on the ethical dignity of word, respect, mutual recognition and solidarity (Betts, 2006).

Based on such *presuppositions*, the following questions arise: a) what educational processes have been implemented to capacitate both health professionals who carry out sanitary surveillance actions, and those in the family health teams, for this practice?; b) is it possible to articulate such practices based on the family health locus, having health promotion as guideline?; c) how can we exert positive impact on health within the families, guided by integrality, co-responsibilization and empowerment of fellows targeted by the actions?

However, it does not propose a definitive answer for the above mentioned questions, but to make an initial approach and critical reflection on these issues, in a dialogue with some authors and official documents.

The first step was to choose documents and literature. The six letters from the International Conferences on Health Promotion (OMS, 2005; Brazil, 2001a) were analyzed, focusing on action fields and on the roles of mediation, education and health defense, and the Health of the Americas Project (OPS, 2002), which discusses the "new" public health, its basic functions and social practices. Then we analyzed documents of the Brazilian Health Ministry (Brazil, 2006b, 2001a, 1993), highlighting the Family Health Strategy, the Health Pact and the National Politics of Health Promotion; and the National Sanitary Surveillance System, that guide the organization of practices (health promotion, family health and sanitary surveillance). As complementary technique, scientific publications were analyzed - mainly Lucchese (2006), Buss (2005, 2000), Starfield (2002) and Freire (1997), references in this theme.

Based on these procedures – choice of documents and literature – elements were gathered according to their meanings, to facilitate the analysis of the material.

Groups were formed according to the following nuclear categories: a) family health as a health practice; b) health promotion setting in the family health locus; c) intersection between sanitary surveillance and family health practices, as follows.

Family Health as a health practice

The Family Health Strategy (FHS) is a possibility to restructure primary health care, based on a set of actions aligned with the principles of territorialization, inter-sectoriality, decentralization, co-responsibilization and prioritization of population groups at risk of sickness or death (Brazil, 1993). Since the 10th National Health Conference, in 1996, this strategy has been an important expression of the national health politics, and has been pointed out as being able to change the hegemonic curative model, to fulfill the guidelines of the Unified Health System: integral health care.

The concept of Primary Health Care (PHC), as conceived by Starfield (2002), points out that services at this level of attention must be: *community-oriented*, aware of its health needs, according to the economic and social contexts; *family-centered*, able to respond to its demands; *culturally competent*, to recognize the

different needs of population groups, understanding their representations of the health-disease process. These propositions have interfaces with the FHS, understood as politics to reorganize the Brazilian health system.

So the re-organization of primary health allows a new work process, where the link professional/patient and co-responsibilization of both staff and population are requirements to achieve resolution and humanization in health care. There are several health actions on this level and they have great impact over populational morbidity and mortality patterns. According to a joint research work carried out by the Brazilian Health Ministry, São Paulo University and New York University, for each 10% of coverage of the Family Health Strategy, infant mortality rates are reduced in 4.6%⁴. The Family Health Expansion and Consolidation Project [Projeto de Expansão e Consolidação da Saúde da Família – PROESF], carried out in 2004 and 2005, produced several papers containing evaluation results. We point out Szwarcwald (2006), whose work best indicates the potential to change health care indicators. Based on these facts, it is expected that primary care offers high quality, resolute services, valuing health promotion and protection, as part of a hierarchized system (Costa & Carbone, 2004).

In order to tackle the complexities of primary health care in an unequal society, the family health team must be closer to the population, what is not clearly noticed in “traditional” primary care units, where organization is centered on the biomedical health care model. So the family health team would be prepared to operate the concept of integral health care. Integrality concerned with health practices and acting beyond demands, usually in health care, and that, while proposing health protective actions, be able to do it in a suitable manner, preventing future risks. Consequently, integrality as a broad comprehension of the fellow’s needs; the ability to place the offers adequately, so as to identify the best moments to make such offer. This means being able to recognize the need to adapt health care offers to the specific context of the situation where fellows meet the health staff (Mattos, 2004).

To account for the new role played by the health staff, this team must change its practice in health education, no longer facing the problems (whose limits and possibilities are given by educational interventions) in an authoritative and normative manner. The challenge is to propose culturally sensible interventions, adapted to the population contexts. To fulfill this, health practices must be regarded as social and cultural realities (Trad & Bastos, 1998), health education techniques must be emancipatory and its main instrument must be dialogue (Alves, 2005). It is undeniable that health education practice is also able to multiply health care actions – *preventing diseases and / or promoting health* – and so it is subordinated to the immediate and mediate objectives of services, as well as to their structure.

The above mentioned limits and possibilities of educational interventions must be considered in the light of the social dynamics and changes in the world of work established by modernization. This imposes productive flexibilization, new work organization forms, stronger competition, technological revolution, and requires a new subject of knowledge, more autonomous and in a constant learning process. The worker must articulate several specific knowledges with ethical and political, communicational dimensions, and interpersonal relations, that form the subjectivity of mutual relationships, and share of ideas, and great part of this knowledge is built in the work environment (Carvalho, 2004; Deluiz, 2001).

Changes in the world of work have showed health professionals the need to develop competences that go beyond diagnosis, prevention, planning, interference, proposing solutions, ruling, managing, negotiating and evaluating health. They require ability to negotiate, to carry out cooperative work and share decisions. Particularly in health formation, such requirements imply an articulation of several types of knowledge: scientific and technical knowledge, professional formation and implied qualities, in work experiences and social life; supporting the establishment of multiple relation among peers – professional staff and community – that stimulate collaborative and exchange processes, as well as in the development of significant processes that comprise not only the know-how, but the review of thinking manners (Tavares, 1998; Offe, 1991). This posture demands a previous educational process, on the part of the health professional, which develops his creativity to welcome the patient’s needs. Freire (1997) and Bell *et al.* (2003) highlight that to educate is to respect the pupols autonomy, it means to be aware of the “unfinished” human being, and to create possibilities for dialogue, recognizing, at the same time, that education is ideology. This reflection on the professional’s capacitation in the contemporary globalized scene is worrisome, due to the performance that is expected from the family health staff in particular, who suffer the consequences of the inadequate professional formation and are not sufficiently trained in the public health area (Gil, 2005).

Reorientation of services, objective of the FHS, is one of the five action fields of health promotion, which replaces the incorporation of determinants of the health/disease process both for teaching health professionals and for its practice, and points to the isolation of the health mechanicist concept still prevailing in the contemporary health care model (Tavares, 1990). It means to overcome a practice still referred to the hospital-centered health care model, centered on individuals and on curative medical action, to search in everyday care, a broader view, more consistent with health promotion, reaching individuals and the community, and shifting the focus on the fellow's disease.

Concerned with the way people are cared for in primary health units, privileging their knowledge nucleus to act only over the disease, Cunha (2005) proposed the application of the amplified clinic in primary care. It aimed to change the way of taking care of the individual and the community, improving the offer of healing tools beyond the traditional medicine, and understanding the particular expectations of each patient, considering the therapeutic approach less normative and collectively constructed among professionals and individuals.

Finally, primary care is where most part of health problems are solved, and the genuine place to carry out integrality and social control - more than attributes, these are SUS's values. The challenge is to operate basic care, called primary by some authors and considered *fundamental* (plagiarizing education) by us.

The health promotion scene in the family health *locus*

Health promotion, defined as the process that empowers population to control health, thus concerning individual and collective welfare (WHO, 2005, 1986), has been the center of debates and scientific production. The Ottawa Letter (WHO, 1986) proposes five fields of action for health promotion: health-friendly environments; making of healthy public policies; strengthening of community action; development of personal abilities, emphasizing health information; health services re-orientation.

Considering that for SUS, integrality decentralization and social control are guidelines, its health care network must be valued to become a privileged space for sociability and politicization of users, workers and managers, spaces that help improve the ability of fellows to reflect and intervene in society (Carvalho, 2004).

The convergence between the fields of action established by the Ottawa Letter, ratified by the Bangkok Letter (OMS, 2005), and SUS's guidelines, from the conceptual viewpoint, has been matured along the past 20 years. The challenge is to transform these premises into practical actions, considering the complexity of the social and cultural environments where health actions are carried out. The other aspect of this same challenge is to articulate determinant and/or conditioning factors involved in the genesis or maintenance of health/disease problems and to transcend the biologicist approach prevailing in everyday practices.

In general lines, this is the health/disease issue that demands primary care services, and which so far – in Brazil – have been insufficient to meet the basic needs, concerned with the configuration of poverty that determines the several forms of being alive, sick or dead in most part of the population. Needs whose answers are not always found in the health sector, and for this reason require inter-sectorial actions (Tavares, 1998).

The objective is to overcome procedures that hinder, in practice, the vision of how the social and the biological facts interfere in the health/disease process. That is, to conceive and to incorporate the social as an important dimension of this process and to perceive it as a historical reality, socially built, identifying it in the individual. To proceed with the re-orientation of services, health promotion action at primary care must be formed by activities of several workers, formally enabled to carry them out as *institutionalized care* (italics by the author), and are aimed to integral care to health care needs, with actions in the determinant factors and the consequent search for inter-sectoriality" (Tavares, 1998).

According to this analysis, the health practice context deals with several types of knowledge. One comes from science, refers more to the concept of disease than of health, and the other arises from the subjective

experience of disease and health of the individual and population. Departing from the idea that the formation of health professionals is based on the knowledge of disease, what efforts are needed to allow an approach that takes health into consideration? There are some possible answers for this question: investment in continuing education for these professionals, as a methodology to apprehend knowledge arising from practice; in the strengthening of local health units; and in the formation of social fellows committed to the operation of a broad health concept. For the existence of knowledge and the recognition of health needs are not enough to face such a complex practice context. There must be a professional with ethical and political values, and competence to learn beyond his knowledge nucleus, overcoming dichotomies between collective and individual practices, and able to recognize, invest and act on the existing social resources. Finally, recognizing the challenge to be tackled, one needs a professional able to invest in the partnership with the population and with the other health professionals, including the ones from the sanitary surveillance.

So the qualification of health professionals' practices is the main tool to transform the approach to patients, family, community and care re-orientation, mainly because these professionals are in charge of developing health education actions, important to meet the FHS's objective, to promote health and sanitary surveillance, as we will see in details.

As a result of this analysis, we see the convergence of proposals of the family health strategy and health promotion, being the former in a privileged place for intervention actions in health determinants, as preconized by the latter. It is expected that the professionals involved in its development are more apt to face, in this complex context, the contemporary sanitary challenge. The field of social epidemiology reflects upon this complexity when it brings the focus on attention, formerly concerned with health risk factors, to closely examine the social context where such risks occur (Carvalho, 2004).

Some studies (Valla *et al.*, 2004; Valla, 2000) emphasize the importance of social support strategies for health maintenance, diseases prevention, and to facilitate convalescence, where health education becomes necessary to set up conditions for human development, based on equity, sustainability and democracy - values addressed at health determinants, according to health promotion guidelines (Tavares, 2004).

We insist that professional capacitation is an instrument to make primary health care operate. Training of professionals must be dialogic, critical and reflexive. Similarly, professional and population must get in touch with one another. It is possible to introduce, in the everyday practice of FHS teams, health promotion actions, to establish partnerships and articulations among the several social segments, and to implement the fields of health promotion. The critical dialogue may lead to the emancipation of individuals and to ensure health with quality of life. According to Heidemann (2006), the incorporation of health promotion actions is still far from the concrete practice of health professionals, because it is hard to incorporate them to their work process, especially when still there is a health care model based on biomedicine

What is the insertion of sanitary surveillance practices in the family health practice?

Up to this point we have worked with the idea that health promotion guides a new practice, able to transform the health arena. We defended that family health is a strategy to build a new health practice, able to help implement the dimensions that the broad concept of health places for the organization of integral health care. Now we must reinforce the necessary approach of the sanitary surveillance towards this reality, overcoming the little social visibility that surveillance has had so far.

Conceptually speaking, Sanitary Surveillance is a set of institutional, administrative, programmatic and social strategies, integrated and guided by public policies designed for the social production of health, based on services, integral actions and essential practices to defend and promote life within environment. Surveillance actions are developed through the exercise of management and sanitary actions, supposedly democratic and participative, in a team work basis, addressed to the populations of specific territories, under their responsibility. In order to extinguish, reduce or prevent risks to health, a set of actions must be articulated, including integration with primary care actions.

Abroad, the institutional arrangements designed to fulfill public health's basic functions of regulation and inspection vary from one country to another⁵. In Brazil, both this arrangement and the practices comprised in it are called sanitary surveillance. According to the Brazilian Constitution, it is part of the SUS and must intervene in health risks among the population, no matter if these risks come from the environment or the production process, trading and consumption of goods, as well as services rendering of sanitary interest. In other words, sanitary surveillance actions lay in the scope of social relations in production and consumption, which originate most part of health problems requiring intervention (Costa & Rozenfeld, 2000).

Historically, Sanitary Surveillance has the power of administrative police in the field of health, its most visible face for society. Due to this power, which ensures it the ability to intervene in sanitary problems, the Sanitary Surveillance is in charge of restricting individual rights on behalf of the public interest. Its types of action comprise activities of authorization (registration of products, license and authorization for business), normatization, health education and communication with society⁶. Authorization and normative activities assign it a character of regulatory action, of State action, and must be carried out by public agents assigned for such⁷; therefore, these activities cannot be performed at present by the family health teams.

However, without the education and communication activities which should permeate health care, especially in primary care, sanitary surveillance has not been successful. On one hand, there is its specific know-how, concerning quality and sanitary safety of services and goods, which must interact with the population's and professionals' knowledge of other health care actions. So, in dealing with services and goods of everyday life and concerned with people's basic needs, the sanitary surveillance becomes a privileged setting for health communication and promotion. On the other hand, in the interaction between sanitary surveillance and society, one must also consider its participation in the definition of the assumed risks, thus reducing the eminently technical characteristic of the regulatory decision-making form that excludes the population.

The organization of municipal sanitary surveillance services is quite variable among the Brazilian municipalities. The professionals have different educational levels (high school and graduation), and different types of graduation course. According to the 2004 National Census of Sanitary Surveillance Workers, 80.4% of municipalities had sanitary surveillance workers, and in 23.7% there was only one worker; from all, only 32.5% were graduated. In relation to the type of graduation, 18% were veterinarians, 13% administrators, 12% pharmacists, 8% nurses, 6% dentists and 5% physicians. Based on this data, the following tasks were considered challenges for human resources in sanitary surveillance: to foster graduation for workers with high school level; adapt workers to the needs and attributions of services; create and implement a continuing education program; and to create mechanisms to set and value workers (Reis *et al.*, 2005).

Sanitary surveillance actions carried out in the municipalities also vary, and comprise, in health care services, offices (typical municipal action) and services of medium and high complexity (generally a state action). However, there is a basic sanitary surveillance action which is more regularly developed and holds significant potentiality for dialogue with the FHS. This is the surveillance over pharmacies, food business (butcheries and supermarkets), and medical and odontological offices (including FHS units).

There are still a few initiatives of education and communication developed in the scope of sanitary surveillance⁸ and there is a large space, poorly explored, for educational action in sanitary surveillance, both concerning awareness of risks to health, in everyday attitudes and situations, and concerning citizenship rights (Lucchese, 2006).

Considering the little social demand for collective actions of health promotion and protection, and the restrict and particular space where sanitary surveillance established itself, one of the main challenges is to ensure that educational actions reach the population and that health protection resources are used in the practice of every health professional. A legitimate way of searching this approach is through the partnership with family health teams, whose health agents are closer to the population.

Based on health promotion proposals, sanitary surveillance is co-responsible for the development of promotional actions, and reinforces sanitary awareness through information and communication, among others. A first issue is: how can we communicate with society in order to qualify surveillance in face of

challenges and bring it near to health promotion actions? That is, how can we put communication with society into practice? For this purpose, considering FHS practices, we will point out the opportunity of sanitary surveillance to work, together with community, information and communication in a contextualized way, as demanded by the best effectiveness in risks control.

A significant opportunity for such communication is the moment when families are registered and resources are mapped, carried out by the community agent, when the community's physical, environmental, institutional and social resources are described. On this occasion, the institutional spaces where sanitary surveillance actions will take place can be mapped. It is expected that the community informs about the space where they live, including information on the quality of health services. The sanitary surveillance is in charge of monitoring the quality of health services used by the population, and its main attribution is to diagnose problems of services and to propose solutions. The awareness of users on the importance of using satisfactory services points to the possibility of progress in the exercise of citizenship, conquered through the joint orientation of surveillers and other health professionals.

This partnership allows that sanitary surveillance professionals get in permanent contact with the population, during the monthly household visits and meetings proposed by the FHS staff, whose practice exceeds the boundaries of services and allows a new space for interlocution.

The family health team may be the link between community and sanitary surveillance team. The community agent is the first professional with whom the community identifies itself. He must be a leader in the community and has to be aware of the community's social and geographic context. He is the first professional to identify risk situations that may lead to epidemiology and prevention, as well as to sanitary surveillance. Some risk situations, as discontinuous treatment, abandonment of elderly, children neglect, alcoholism, excessive migration, unemployment and others are identified everyday by these professionals, and approached by the whole family health staff. So he must incorporate important risks or injuries in the scope of the sanitary surveillance, such as: alimentary intoxication, environmental contamination, work risks, inadequate use of medication, among others.

When sanitary surveillance and FHS professionals share with the population the surveillance of risks, they empower the population and promote social control. The improvement of social control, which is a central issue for the family health, is also regarded as fundamental for sanitary surveillance, as it can be seen in the effort to establish auditorships, to open communication channels that allow users to send complaints, reports, suggestions and praises. Since the 1st National Conference on Sanitary Surveillance ("to implement the Sanitary Surveillance National System: to protect and promote health, building citizenship" – Brazil (2001b, 2001c), issues like social control, public responsibility, information democratization, ethics and citizenship are in the agenda of sanitary surveillance.

The first point in the dialogue between family health and sanitary surveillance concerns the idea of territory. Traditionally, sanitary surveillance considers FHS a political and administrative division, which means jurisdiction. On one hand, the fiscal component of its action justifies it. So surveillance actions are circumscribed to the federative entity responsible for that action, so as to have legal force. In this sense, there may occur simultaneous actions in the three governmental levels in the same place. For the FHS, to delimitate areas for teams to work, for clientele adscription, is a geographic issue, but generally it is based on the amount of population, not considering the social and political dynamics of territories (Pereira & Barcellos, 2006).

However, the concept of territory, originated in Geography, is more compatible with collective health practices, where territory is the space lived by people (Santos, 2003), and also is the setting where all enterprises and institutions act. So the concept of geographic space represents a category of synthesis and convergence which generates the several processes involved in life conditions, environment and health of populations (Barcellos *et al.*, 2002), and holds a large potential to explain and identify problems (Monken & Barcellos, 2005). This concept of geographic space, of territory-process, which is not incompatible with that of jurisdiction, has been more employed in family health, since it is articulated with the proposals to change the health care model.

The comprehension of territory by technicians and users of the health care system tends to influence the way this territory will be incorporated to practices. In its origin, the FHP tries to regard the territory towards a multi-territorial perspective. But the operationalization of this idea meets reductionist trends, and makes local managers, community agents and the general staff have different ideas about territory (Pereira & Barcellos, 2006).

Another issue is financing, within the context of transformations brought by the 2006 Pact. In 2006 the Pact for Health was approved (Brasil, 2006b), as result of intense discussions involving technicians and the direction of several areas of the Health Ministry, the National Council of Municipal Health Secretaries (CONASEMS), and National Council of Health Secretaries (CONASS). This pact retakes issues on decentralization, integrality and social control, besides financing. The progress identified here bears on the strengthening of the FHP and on the definition of health regions, ensuring the offer of services of low and medium complexity. Unfortunately no progress was found in tasks concerning sanitary surveillance financing.

Formerly, the Primary Care Minimum Tax (PAB), among other actions, financed the municipal family health and sanitary surveillance, and primary health care actions. Among the five financing blocks established by the Pact, one is for Primary Care and one for Health Surveillance. The first, regulated by Act n. 204/2007, aims to support the family health (except pharmaceutical care, supported by its respective block) (Brazil, 2007). The health surveillance block is formed by resources previously destined to the epidemiological and environmental surveillance, and to the sanitary surveillance; and these resources can shift from one component to another, and may weaken the process of construction of these services at municipal level.

With regard to the Primary Care Pact, nowadays it is widely known that the FHP is nationwide⁹ and that its network requires implementation. Among others, the progress comprises: multi-disciplinarity, which becomes relevant with the inclusion of a dentist in the team; valuation of the work process, including broad family care, monitoring of care through follow-up criteria; obligatory input in information systems, which allows the dialogue among the many federative entities; qualification and capacitation strategies of teams based on definitions of attributions, continuing education and investments in graduation. The Management Pact clearly defines the sanitary responsibility of each level of the SUS: federal, state and municipal, overcoming the previous qualifying process. The joint decentralization is highlighted, where integral health actions are ensured with the creation of the Health Regions. These regions are territorial portions in a continuous geographic setting (not restricted to the municipality) comprising a network of actions and services that grant a certain degree of resolubility to the municipality, with enough primary care and part of medium complexity.

The municipality is in charge of primary care and health surveillance actions. The region must ensure access to complementary health actions. So, politically speaking, there is a scene of a new sanitary responsibility, joined by managers, able to implement integrality among the actions on hand. This integrality is no more restricted to the rationalization of services offer, conceived as “*integral health care*”, within the perspective of medical, individual, curative care (Teixeira, 2002), since the municipality has already embodied the health surveillance actions. The FHP, which in the present scene fails to join, form and qualify its workers, is under the municipal manager’s responsibility, who must also ensure health surveillance actions, including primary health surveillance actions. The management of the sanitary risk, although perpassing the three government levels in the same geographic territory, has, at local level and as a municipal health system, the duty of exerting social control, which will be strengthened by the joint action of the FHP and the sanitary surveillance.

Independently of rules and management forms, sanitary surveillance must enlarge its object of action and working manner. Beyond products and services, it must include as object of action the determinants of the health-disease process and of quality of life, and beyond inspection, it must include in its work, communication techniques (with society and other health professionals) and inter-sectorial actions.

Final remarks

So far we have defended the idea that the “new” primary care (*fundamental* care, in our opinion) is able to become more resolute, approach integrality and to bring humanization to services; and that sanitary surveillance is a partner in the task of protecting and promoting health. We mean that we believe in the theoretical construction of the SUS and its proposals, and we do not forget that humanization of services must happen everyday, at the *point* (employing a jargon of the area). The meeting of user, professional and team is qualified by the investment in educational/formative processes for staff and users, with the most effective social control. Education, proposed as a tool, must recognize its emancipatory ideology of a new relation. This is the challenge, to invest in human resources, putting communication with the population and exercise of citizenship into practice.

As it has been pointed, to implement the concept of integrality is not an easy task. It is a change, not only of strategy or reorientation of the health care model, but of value, in which the user does not feel that the system is excludent and that it favors him, offering services that are close to his needs, but that he has the right to such services. And that the staff humanizes its work, refusing the exercise of power in its relationship with the user. In doing so, we will meet with the strengthening of community action and a new interlocution space.

We cannot ignore the great progress of the FHS in Brazil, in the last years, nor the effort of the sanitary surveillance to capacitate its professionals and decentralize its actions. However, the family health coverage still needs improvement, as well as the surveillance structure. The capacitation processes for health professionals, although deserving a lot of attention and investments on the part of the Health Ministry, still are incipient in some regions and do not meet the population’s needs.

Still there is a lot to be discussed on the issue of health practice at the SUS, health education, professional capacitation and social control. Most of all, there is a lot to be done. However, we do not quit the idea that this is the time to implement a Unified Health System able to promote, protect, assist and recover the population’s health.

Colaborators

Gisele O’Dwyer conceived the study and supervised all aspects of its implementation. Maria de Fátima Lobato Tavares assisted with the the discussion, writing and bibliography reviews; and Marismary Horst De Seta assisted with the writing and bibliography reviews. Ana Silvia Gesteira translated the article.

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2 Since the 1990's, some epidemiologists have been trying to disseminate the epidemiological knowledge among health institutions. The proposals of the Health Surveillance arose from the need to break with the traditional dichotomy between surveillance and assistance, that is, surveillance actions should be incorporated by every health care unit. The Health Surveillance model appeared in a context which favored the incorporation of epidemiology in health care services (Paim, 2003), and its actions comprised the strengthening of epidemiological and sanitary surveillances, nutritional surveillance actions for risk groups, surveillance in the field of worker's health and environmental surveillance, without losing sight of health care itself (Teixeira, 2002). In a systematic way, there are three branches in the so-called "surveillance of/for/in health". The common idea is access for epidemiology, both concerning the analysis of health problems, and the implantation of new assistance practices and models. The first one analyzes health conditions, including diseases and disorders beyond the traditional one in epidemiological surveillance - the communicable

diseases. The second one corresponds to the institutional integration of the epidemiological and the sanitary surveillances, and was founded on the creation of surveillance structures in subnational spheres, in early 1990's. The third one aims to become an alternative health care model, with redefinition of sanitary practices and incorporation of other fellows, including representatives of the organized population (Teixeira *et al.*, 1998).

3 Abrasco, Cebes, Abes, Rede Unida and Ampasa. **O SUS pra valer: universal, humanizado e de qualidade.** Manifesto do Fórum da Reforma Sanitária Brasileira. Rio de Janeiro, July 2006. Available at: <<http://www.abrasco.org.br/publicacoes/arquivos/20070306142552.pdf>>. Accessed on: July 3, 2006.

4 Available at www.saude.gov.br/dab/atencaobasica, Accessed on July 2, 2007.

5 Through an agency and direct administration, the sanitary control among countries unfolds in: food and medication; medication and food, separately; in health care services, in some countries, sanitary regulation is based on market mechanisms, such as accreditation. In this sense, there is a lack of international coherent experiences that serve as reference for the Brazilian model of sanitary surveillance.

6 Communication with society can be understood as the one that aims to empower the population, and to improve its quality of life and consumption pattern, reinforcing the “sanitary consciousness” and citizenship, at the same time that reduction of exposition to unnecessary risks is expected. So it embodies and transcends the so-called risk communication, comprised in the management of the sanitary risk.

7 Public agents invested in this function are civil officers admitted through public contest, or designated commissioned officers. Without it, inspection actions may become invalid.

8 Among these, there is the Cultural Exposition of Sanitary Surveillance and Citizenship (<<http://www.ccs.saude.gov.br/visa>>) and educational material for health counselors.

9 According to the Health Ministry, the Family Health Strategy reached 5,106 municipalities in 2006, covering 46.2% of the Brazilian population. Available at: <www.saude.gov.br>. Accessed on July 2, 2007.

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