

Integrality: life principle and right to health

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Integrality: life principle and right to health

Objective. To understand the health integrality in the daily work of Family Health Strategy (FHS) and its concept according to the managers in Jequitinhonha Valley, Minas Gerais, Brazil. **Methodology.** This is a multiple case study of holistic and qualitative approach based on the Quotidian Comprehensive Sociology. The subjects were workers of the Family Health Strategy teams, the support team and managers in a total of 48. **Results.** The results show the integrality as a principle of life and right to health and to contemplate it in the quotidian of doings in health, others principles of the Unified Health System may be addressed consecutively. The universal right to health care needs is declared in contemplation of integrity of being, the idealization of a subject-centered care, one that is our aim in health care, which signals a step towards a change of attitude in seeking comprehensive care. **Conclusion:** It is considered that the principle of integrality is a difficult accomplishment in its dimensions.

Key words: comprehensive health care; health services accessibility; right to health; the family health strategy, sistema único de salud.

Integralidad: principio de vida y del derecho a la salud

Objetivo. Comprender la integralidad en salud en el trabajo cotidiano de los equipos de la Estrategia de Salud de la Familia (ESF) y de gestores de municipios del Valle de Jequitinhonha, Minas Gerais, Brasil. **Metodología.** Estudio de casos múltiples holísticos y cualitativo, fundamentado en la Sociología Comprensiva de lo Cotidiano. Los sujetos fueron trabajadores del equipo de ESF, del equipo de apoyo y de los gestores municipales, para un total de 48. **Resultados.** Los hallazgos presentan la integralidad como un principio de la vida y el derecho a la salud ya la contemplan en el cotidiano del hacer en salud. Los demás principios del Sistema Único de Salud deberán ser consecutivamente contemplados. El derecho universal a la atención de las necesidades de salud es declarado en la contemplación de la integralidad del ser, en la idealización de una atención centrada en el sujeto que es nuestro objetivo en la atención en salud, lo que señala un paso hacia el

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cambio de postura en busca de una atención integral. **Conclusión.** Se considera que la integralidad es un principio de difícil implementación en sus dimensiones.

Palabras clave: atención integral de salud; accesibilidad a los servicios de salud; derecho a la salud; estrategia de salud familiar; sistema único de salud.

Integralidade: princípio de vida e de direito à saúde

Objetivo. Compreender a integralidade em saúde no trabalho cotidiano de equipes da Estratégia Saúde da Família (ESF) e de gestores de municípios do Vale do Jequitinhonha, Minas Gerais, Brasil. **Metodologia.** Estudo de casos múltiplos holísticos e qualitativo, fundamentado na Sociologia Compreensiva do Cotidiano. Os sujeitos foram trabalhadores das equipes ESF e das equipes de apoio e os gestores de cada município, em um total de 48. **Resultados.** Os resultados apresentam a integralidade como um princípio de vida e direito à saúde e para contemplá-la no cotidiano dos fazeres em saúde, os demais princípios do Sistema Único de Saúde deverão ser consecutivamente contemplados. O direito universal no atendimento às necessidades de saúde é declarado na contemplação da integralidade do ser, na idealização de uma atenção sujeito-centrada, aquele que é o nosso objetivo na atenção à saúde, o que sinaliza um passo para uma mudança de postura, em busca de uma atenção integral. **Conclusão.** Considera-se que a integralidade é um princípio de difícil efetivação em suas dimensões.

Palavras chave: assistência integral à saúde; acesso aos serviços de saúde; direito à saúde; estratégia saúde da família; sistema único de saúde.

Introduction

The implementation of current health policy in Brazil, under the aegis of universality, equity and integrality established health as a right for all. Consequently, in addition to offering an equal attention to all citizens, those over twenty years of implementation of the Unified Health System (UHS) in Brazil search, still, the effective realization of these principles in daily services. For this embodiment, the emphasis of care is responsibility of Primary Health Care (PHC) among the set of actions and services developed by UHS, with the incorporation of the Family Health Strategy (FHS), proposed by the Health Ministry from 1994, which reorganized the care logic, focusing on the family as a programmatic action health unit and no more, or solely, in the individual or disease.

To occupy the central role in the organization of health systems, PHC aims to seek to improve the health status of the population equitably, to

decrease costs and, consequently, increased user satisfaction with the services network. Therefore, the FHS can be found today in more than 90% of the Brazilians municipalities.¹ In this context, integrality, object of this study, presupposes access to properties and services, formulation, management and participative control of public policies, subject/professional interaction without losing sight of what is common to all and should be universal: the right to live and be treated with respect for the integrity and dignity of the human condition in situations of health, disease and death. Also, assumes the care focused on the individual, family and community - social inclusion - because, over the years, the understanding of integrality has been expanded to include other dimensions, increasing the responsibility of the health system with quality of attention and care. It implies, in addition to articulation and harmony between the health production strategies, the expansion of listening, either individually and/or

collectively, in order to shift attention from the strict perspective of the illness and its symptoms to the host in the history of subject, their living conditions and their health needs, respecting and considering its specificities and its potentiality in the construction of projects and the sanitary work organization.²

The expansion of the FHS has favored the equity and universality of care, since the teams are implemented, primarily, in communities before with limited access to health services. However, it is unacceptable, only the expansion of the statistics of the number of teams, that the integrality of actions is no longer a problem in daily care. Therefore, are necessary qualitative analyzes of the work of FHS performed in Brazilian municipalities, particularly regarding health practices and quotidian work processes.³ Thus, the proposal of FHS was reported as an important challenge, immersed in a deeply scenario influenced by the biomedical model and that proposes a break with this care model and the construction of a new practice, with a new ethical dimension. However, in practice, this strategy has not yet achieved its objectives in the PHC, because “without changes in assumptions and paradigms which guided the Brazilian healthcare model, cannot be expect satisfactory response to the problems that arise in day-to-day interaction of the population with health services.

For health actions follow the principle of integrality by the demand of population service, it is needed an assimilation of this principle in favor of the reorientation of the care model: integrality, humanized and committed.⁴ One may wonder: how the professionals of the FHS team, the support team and managers understand the integrality in the daily practices of health? This article originates from cropping a doctorate thesis⁵ which aimed to understand the integrality in health in the daily work of the Family Health teams and municipalities managers in the Jequitinhonha Valley, Minas Gerais, Brazil.

Methodology

The study is a qualitative approach, defined by the methodological framework Multiple Holistic Case Study, based on the theoretical framework of Comprehensive Sociology of the Daily originated from the thesis cited above.⁵ Considering that is in terms of daily practices, of FHS professionals, the support team and managers, which makes possible the construction of integrality with its various interpretations, arise the option to launch the look of Comprehensive Sociology of the Daily based on Michel Maffesoli on the object of study, to understand the integrality through the plurality of views and experiences in the daily work of professionals. The comprehensive sociology engages in describing “lived in what is, content, thus, to discern the views of different stakeholders”.⁶

The comprehensive sociology shows the potential of reflexivity as a cognitive tool, target for social research⁷ and daily life itself, in that it presents about the experience. Relates the subjective and objective dimensions of reality to consider that the actions have meaning for those who practice it.⁶ The study setting are the municipalities Diamantina, Gouveia and Datas located in the Jequitinhonha Valley, Minas Gerais (MG), Brazil. The proposal was carried out an individual case study in each of these municipalities, constituting a multiple holistic case studies, with single unit of analysis for this study was “integrality in the daily work in health” established in three different realities, which, also enabled the literal replication, which allows inference and comparisons with similar situations. Thus, the “analytical conclusions that emerged independently of the three cases were more extreme than those that arise from only one case” and can be reached, in this study, the “common conclusions from both cases, extending in an immeasurably way the external capacity of generalization of the findings in the study”.⁸

The field research, over a period of eight months, was based on a survey of primary data through direct observation and individual interviews.

The invitation to the participants was conducted through direct contact, by the researcher, before the start of data collection and none of the guests refused to participate. In this first contact the survey was formally presented, its purpose and the purpose of the investigation and the Informed Consent. Was approached the respect for ethical criteria, the confidential nature of the information and anonymity, the possibility of leave the research at any time, without any prejudice. The interview was conducted in the participant's environment work, individually, with date and time chosen by him, recorded after release, with an average of 30 minutes of duration and transcribed in full and based on the following guiding questions: i) "Tell me about your daily practice in the Family Health Strategy"; ii) "What do you understand by integrality in health?"; iii) "How do you perceive the development of actions of integrality in the actions of the work team?", iv) "Would you like add something?" (Open space for informant). The transcript interview was taken to the participant for reading and evaluation of its integrity; every sheet were initialed and dated by the informant, giving it validation.

The observation was used as input in the search field. It was held in participant's environment work: Health Unit, home, community. The record of these observations was made in a diary drawn up after each observation period, identified as observation notes. The observation was descriptive in nature, focusing on the proposed subject matter. The three cases were conducted successively in the period of observation and simultaneously at the time of the interviews.

The subjects of this research were workers in the FHS and support teams, including physicians, nurses, nursing auxiliaries/technicians, community health worker, dentist, oral health assistant, physical therapists and managers of each municipality – health secretaries with storage management function, whose participation was voluntary, in a total of 48. As inclusion criteria, was established a performance of at least one year in the work. As qualitative criteria research, the number of respondents was not stated a

priori. In total, were 76 professionals: members of the FHS teams included and some support professional who attended the inclusion criteria, plus managers of municipalities. However, the data of observation presented themselves enough in the 48^o accompanied subject and in 35^o interviewed subject, configuring the saturation and determining, thus, the end of data collection. Saturation in qualitative research, is beyond the point of repetition of the collected information, it is necessary that the data be presented dense, that the defined categories are well established in terms of their properties and dimensions and the relationships be well established and validated.⁷

Data analysis was performed using the technique of Thematic Content Analysis,⁸ that is, an analysis of the "meanings". The analysis phase were: a) The preparation of the material: the record of field notes (230 pages) and the transcription of 35 interviews (100 pages), which constitutes the corpus of research; b) The floating and global reading of the data; c) the exploration of the material through codification, carried out by "text cut in parts, to be categorized and classified with a view to a decoding of the meaning of the parties in relation to the whole, allowing them to achieve a representation of content, or its expression."⁹ Then, by the categorization - which is an operation of classification of categories, which gather a group of recording units under a generic title, gathered this made because of the common characteristics of these elements. In this study, the categorized criterion was semantic, or, the significance; d) Treatment of results and interpretation were processed as intended purpose and the discussion with the existing literature. After a descriptive interpretation of individual cases, were identified converging or opposing lines, i.e., similar or contradictory results, and from this evidence, were proceeded to the analysis of multiple or comparatives cases,⁸ for relevant final considerations, as conclusion of the study.

The research (2008-2010) was developed according to the guidelines and regulatory standards for research involving human beings, National Council of Health (NCH) Resolution

196/96, which requires periodic reviews to it, as needs in the techno-scientific and ethical areas, made by NCH Resolution 466 of 12, December 2012. Thus, data collection started after the approval of the project in the Ethics Committee of the Federal University of Minas Gerais (COEP UFMG), where it received the number ETIC 142/08. The access to the search field has been obtained by permission of mayors and health secretaries of municipalities to conduct the study, in addition IC signed by participants of the research. The anonymity of the participants was guaranteed through the adoption of acronyms that identify each profession listed sequentially, according to the team and the interviewee professional.

Results

In one of the moments of the interview, the subjects of this study established thinking about the integrality that is configured to describe while to order this as a principle of life and right to health. Thus, it was possible to see that the exercise of thinking about integrality to answer one of the interview questions - "What do you understand by integrality in health care?" - was, sometimes, covered by a different voice intonation, the fragmentation of words, stuttering, silences, low or high looks, facial expressions accompanied by monosyllables: good ... hey ... ah ... is ... oh ... expressed in the context of the speeches of the interviewed subjects.

When the effects of these gestures were analyzed in expressive or representative function of communication - the analyzed content - showed that, even today, there is a subordination fixed in absolute parameters, based on rules and concepts to guide people in world in which they live. Often, this fixation on concepts despises the experience and the everyday marked by many values and human issues that consider the multiple meanings of the term Integrality. In fact, this term is very experienced, imbricated between notions and experiences that, when expressed by the subjects,

define this principle among others of the UHS. Thus, the integrality became real in the universal access to health: *Good, integrality is all people have access to health care, independent of any class. After all, the UHS ensures this access, it is universal: So I believe that are two points here that go together, integrality and universality. So it's the same integral access to all health services that the UHS offers (SMS21).*

Effective in solving the attention facing the needs presented: *Hey, (Integrality) I think it's ... you're helping people to have access to all means we have in the city, and if not possible that they have rights to be referred to outside the care offered here ... That thing there outflow and return [reference and counter reference] to the municipality with an answer they were looking out there (ACS52).* As a condition of universality and equity: *[Integrality] I mean, cannot leave the patient without care, I think so, anyone who comes here has to be attended. And I wish it were better served possible, because sometimes, it is not possible due to professional work accumulation (M5).* Regardless of socio-cultural-economic-political conditions: *People do not understand that it is a right for all. Many arrived already saying that sometimes do not feel well going to the Health Unit or the FHS, or to find a drug or to make an appointment. And it is not in this way. It is a right for all! Up because you have to treat everyone equally, that's a prejudice that people have. Sometimes it has the prejudice and has no knowledge of the UHS Act, which everything that the UHS offers is not only for those who have not condition. Also, because if it were, it would be a lot ... belittle people. So everyone has the right to the same health, regardless of whether economic and social situation she is in. It is, in my view, I understand what integrality is. (SMS21).*

Public official has even thinking, "the guy has good financial condition, so why he is in the Health Unit, for what is he looking for?" *I think it's right for all regardless of whether you have a good class or not, if you have condition be paying or not because the UHS is a right for all, regardless of social class as well ... (TE62).* .In

perception and implementation of a health care, user-centered: *In the 1996 [FHS] team I worked at the first meeting, I did various groups and I was wondering: Who is more important here and let a person out there who came to consult ... waiting a bit. And they answered: is the doctor, is the psychologist; is the mayor, no, is the municipal health secretary Then, after they finished, I said,... have a person sitting outside The most important person is the one who is sitting out there. She is our goal. A humble person and came here to consult ... sometimes is unemployed, with problems at home, a number of problems. So there has to have integrality because of that, you know? (M5).*

For recognizing that the subject of attention is an integral being: *The integrality is not easy to Health (laughs). Because health is not only to treat the illness, so I think integrality you have to be treating that person who has a disease. So, is involve, is to stop seeing the individual as tonsillitis, renal colic, the pregnancy. Here we have a person who has a disease. So I think the first thing we have to think when you talk about integrality is this. And the second, the technical part, which is not only the physician consult, not only the nurse consult, not only the health agent, I think that everybody is involved in the process to get to that patient and not see him and turn around and say: Oh! That patient has conjunctivitis, you know that the patient has conjunctivitis, but who is he, we do not know. Do not know to identify his name, and then I think this is to integrate the individual and to integrate the team (M4).* So it depends also an integral care: *I think it is to give full assistance to the user. And besides being a full assistance as physical, psychological or social, would interact with the other principles of life. From childhood to old age (CD4).*

Discussion

The reports of the subjects have overlapping notions that include access to health care,

the resolution as response to needs, equitable service, universality and integrality. These notions lead us to the universal sense, equitable, integral and democratic of UHS. In an attempt to express the understanding of integrality, the subjects say that to have integrality in everyday doings in health, other UHS principles should be included, consecutively. In the 1980s, the challenge in Brazil was to expand coverage aiming to provide universal access to health. The most effective adopted measures were the strategies of the Community Health Workers Program and Family Health, in 1991 and 1994, respectively, in a structuring of the PHC giving assistance to the far places and having scarce resources, where social inequalities were explicit, among them, lack of access to health, goods and sanitary services. In the fragments of speeches, universal access becomes concrete in a continuous flow of health care, which starts and reinforces the PHC as the gateway to that level and to middle and high levels of complexity in health, reaffirming the accessibility of subject to health care.

The term accessibility is understood as “the set of circumstances, from different nature, which enables the entry of each user or patient in network services, at its different levels of complexity and type of attendance. Represents the difficulties or facilities to obtain desired treatment, and is therefore intrinsically linked to the details of the offer and availability of resources.”¹⁰ Access to Health Services can be considered in its various dimensions: the demographic that, in the municipality of Datas and Gouveia, is characterized by 100% coverage of the population by the FHS teams and the support team. The geographical, which features natural obstacles, extensive territory with very dispersed rural population, unpaved roads and, therefore provide accessibility for mobility of teams to rural communities or transport of users in cars provided by the health secretary to its urban areas or to others cities, such as Diamantina, which is the macro-region, or to Belo Horizonte, capital of Minas Gerais, Brazil.

The programmatic dimension plans the actions on a monthly chronogram and, also, in attendance of

spontaneous demand. However, the planned offer of services is restricted to the demands of users. The human resources, in Datas, are restricted to the professionals of the minimum FHS team, oral health, and support professionals: nutritionists, physical therapists, gynecologist/obstetrician, general practitioner and pediatrician. For other specialties, users are referred to the macro-region or Belo Horizonte, which may cause sometimes a long wait, depending on the specialist. As also occurs with access to technological resources, which is configured as the last dimension. Routine laboratory tests, for example, are held in the city itself, however, depending on the complexity, users are sent and the delay in treatment will depend on the risk rating and the availability of shares to be distributed to municipalities affiliated to the Intermunicipal Health Consortium of High Jequitinhonha (CISAJE), based in Diamantina or scheduling in Belo Horizonte.

In another study it was found that, although access and integrality in health care are ensured by the Organic Laws of Health, there were some obstacles to the realization of these principles. Among these are the delay in getting perform diagnostic tests and the excessive waiting time to consult with specialist doctors.¹¹ Keeping the notion of universality, the subject is intended to discuss the participative and inclusive perspective of citizens in health care, such as that which holds the right to health: the UHS is a right for all. In the informant's domain, "the sense of right is understood as something universal, held by all, which is characterized by integrality. Equity, according to this design, threatens the principle of universality and integrality, in that it disregards the subjects in their specificity".¹² Refers, therefore, to equity not as equality in care, but considering "the difference between people in their social and sanitary conditions, with different needs. Thus, an action guided by equity should enable every individual to satisfy their needs, which are differentiated."¹³ In this way, to be opportunity for the all society must be met the needs of the collective and the individual, in its uniqueness, in search of social inclusion. The services must operate in favor of less privileged groups to have,

thus, increased their opportunities, ensuring equity in the results. So, in that sense, equity is closer to the conception of justice than of equality.

The conceptual approach to health equity enables us to state "that the differences of occurrence of diseases and events related to health are mediated social and symbolically. Thus, reflect interactions between biological differences and social distinctions on the one hand and social inequities on the other, as empirical expression inequalities in health. Therefore, treat in a theoretically way the problem of equity takes as imperative to examine human practices, their determination and intent with regard specifically to concrete situations of interaction between socials subject."¹⁴

Underlying every sense of integrality in the speeches of the subjects "is a legal principle: the universal right of attendance to the health needs".¹⁵ Right to health can be understood as "a social practice inherent of the human condition which requires the guarantee of fundamental elements for its implementation: universal access to health care, with necessary resources to provide them, being offered for quality services, in which cultural practices are considered, and education and information are means of their production and social reproduction".¹⁶ Once guaranteed, in the Brazilian Constitution, the universality of fundamental rights to life, liberty and property, everyone, regardless of their origin, right to opportunities to achieve access and resolution of their needs in health services, i.e., the provision of an equitable service thereby contributing to reduce the social difference.

About right to health the Brazilians know, but not everyone knows that there are principles that need to be included in the System for this to be established for everyone. In this sense, some of the fragments point to this question: the right of everyone, regardless of socioeconomic conditions. When we talk about the health of the citizen, legislated as a duty of the State, automatically, we refer to the UHS, which is presented as a policy that should allow both universal accesses to basic health care as to the most complex.

Therefore, the UHS can now be understood as equal, as it provides high-complexity services, for example, organ transplants for the citizen, regardless of their social status, race and belief. For the emancipation of health as a citizen's right it is necessary that the State listen to the requests of them as preparation and supply of a specific health service, thus, only in this way we will really have a democratic state.¹⁷

Thus, it is necessary that every citizen is attended as soon as possible, promptly, with courtesy and efficiency when it has his health threatened or compromised. Thus, it is a universal right to face social inequalities without closing the door to those seeking care, even if it is socially well established. So, there is no possibility of integrality and equity without the guarantee of universal access to health. This universal law in meeting of health needs is declared in the contemplation of integrality of the man, in an idealization of subject-centered care, one that is our aim in health care production. This form of person approach as the subject of health action signals a step towards a change of attitude, in search of an integral care and that attend the needs of people in their specificities. Often, this attention is made possible by proximity, by the professional relationship with the user, promoted in the FHS, which points signals to a paradigm of attention to user-centered health. The discourse highlights the aim of health work is to attend the problems of the people, i.e., their needs, is to have the user as the center of attention.

The structure of PHC as new space of health practices - considering in this context the FHS - has "valued and reframed the figure of the subject and his subjectivity in preventive interventions and/or clinic healing."¹⁸ This structure is "determined in most cases by external pressures to own medical practice or by physicians."¹⁷ However, the incorporation of this subject to clinical knowledge" is still doing in an incipient or decontextualized mode, with a weak perception of the meaning of illness, their health needs and the most appropriate interventions to be carried out."¹⁸ The challenges for the XXI century in health care require differentiated positions in the appreciation

of the subject; expecting of the Health Services facilitation, not only of the user/subject, to attain their fulfillment, but also the professional, so that both can live with the dynamics of the world, without losing their identity as a subject, citizen and professional. That is, allow "access to a wider human. Passage index of individualization to individuation. This implies the death of a self, identified only by the rational consciousness. This, aiming to give a future to the summoned subject could have a future and, thus, participate in the integrity of the human self."¹⁹

Despite the lack of conceptualization of what is integrality guided by theoretical concepts, reports describe a daily work that permeate by nuances, which establish notions made from integrate practices in doing Health. For the different ways of understanding the UHS also represent factors that can interfere with accountability and resolution of the actions, since the integrality depends on the universality and equity in the attendance of the user to the clinical and sanitary accountability of professionals in the development of comprehensive health actions. Somehow, "the concept may be something that excludes, restricts and limits the make and live, characteristic of daily life, and the concept aggregate, mould."⁶

The term integrality carries several senses and meanings, but even knowing its implications for the quality of the production care, it is considered that develop it in everyday health care is not easy. The notion of integrality as a principle of action seeing the other as a whole, should guide the professional and the team, to meet the person, listen, understand, finally get involved and, from this point, take care of their demand and need. When all team members know the needs of individuals and families, the approach is total and is more effective, because the entire team participates of the care. However, the informant knows in a conscientious way that this is not easy for Health, so we continue to treat the illness. However, not only is innovative by the adoption of the various senses and meanings of the term, because "most of the time, integrality is being captured by models of traditional care production

health practices that are corporate-centered.”²⁰ This fact “is currently a challenge for integral care with organized labor, traditionally, in an extremely installments, with difficulty also to the universal.”²¹ In one study,²² it was found that the FHS has allowed some progress in health care, but it is necessary to redirect the actions to be taken to achieve the transformation of the care model, with the effective involvement of users to ensure their needs, proposing an opening horizons to conquer the right to guarantee a healthy lifestyle.

However, other research²³ points out that “there is no how to deny that the equity, integrality and resoluteness are imbricated in daily of Health, sometimes by the presence, sometimes by their absence. By the presence, when some speeches show that the Health Unit door remains open all the time and that access is for everyone. And in the fact that it can no longer attend only the physical body, indicating that, coupled with the physical, are the social and cultural. By the absence, were emphasized the fragmentation of daily actions, the lack of time to take care as liked, as desired, the separation between managing and caring. In the presence, are described; in the absence, it is proposed to reflect on what could be improved; in which way the equity and integrality can be showed to the daily work in health be resolute. “Several integrality concepts were addressed by subject and discussed in this article, but how to interact with the other principles of life, brings us to the relation caregiver/admitted by the service in an integral approach of both. There is no how to separate or put limits in this interaction, since all are caregivers’ needs to be cared for to live and have quality of life.

Finals considerations

As constitutional law, health should be guaranteed by the universal, equitable and integral service in the Brazilian health system, thus the results emphasize that to have the realization of integrality the others principles of the UHS need to be implemented. Also, points us to signals of paradigm changes: the user as the center of health care. Increasingly, the daily spaces of

knowledge construction should be considered in this process of effectiveness of integrality in health care process, because it is the act that makes this principle happen or not. Do not just idealize integrality; it is necessary to make it happen in the actions and attitudes of each one who is inserted in the process. Once, integrality was connoted by the subjects of research as a principle of right to health in respect for human life, unique in born, live and die. So, is achieved when integrated actions respond to the health/disease needs demanded by UHS users.

Reflect on integrated health actions, considering as scenario the three studied cities, reinforces the need for further studies facing the amount of different Brazilian realities. Ideologically, we can think that there are changes, even subliminal in daily tasks in health, with subjective efforts of those who are ahead of the sector. However, such changes should reflect in the quality of life of people and forming themselves into an attention to health centered in the integral human considering all dimensions. Although the study was conducted in three municipalities in the Jequitinhonha Valley region, which can be considered a limitation because it is a region, allowed inference and comparisons with similar situations. Sucked up, the ideas presented here can help professionals, teams and local managers, providing data and tools that became enable the improvement of deployed services, analyzing the factors that influence the effectiveness of the integrality in health care, and serve as basis for possible interventions aiming to improve the service to users of the FHS of the investigated realities, as well as similar realities, since the presented results, coming from different municipalities are similar in several moments, allowing literal replication in other realities, which gives it an capacity to generalize.

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