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CONSTITUTION AND PROFILE OF A COMMUNITY ASSISTED BY THE FAMILY HEALTH STRATEGY

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ABSTRACT
The objective was to know the socio-economic profile, and the constitution of the community, aiming to subsidize health care planning. It is a qualitative, descriptive research. The data collection consisted in the use of Rapid Participative Assessment and as data source field observation, interviews with key-informants and document analysis were used. It occurred in 2008 in the coverage area of São José Family Health Unit, in Santa Maria, Rio Grande do Sul. The data was analyzed through content analysis. The survey results describe the formation, constitution, community features and dimensions of social determinants of health. The conformation of the community reveals a singular territory, while complex and heterogeneous, favoring the intersetctoral approach. The unveiled social determinants of health enabled the identification of vulnerabilities, great social, economic and cultural disparities. Such dynamics and complexity should be considered in all actions in health developed in the area, mainly in the local planning.

Keywords: Community health planning. Primary health care. Unified health system. Nursing.

INTRODUCTION

It is known today that being healthy or getting sick is not something casual or intended for this or that person or population. This is an historical and social process, determined by how each person or population group is organized in society, and the resources at its disposal to live[1]. In this way, the health problems, the social representation of the disease and its severity are distributed unevenly among populations, either through different social origins, unequal access to actions and health services and other social policies[1].

In this context, the social determinants of health must be considered as essential tools for planning in health, since they influence the occurrence of health problems and their risk factors in the population. These can be related to social, economic and political factors, which in turn can determine the search by health services, as well as the population more vulnerable to health problems[2].

The expanding of the understanding of health concept and its determinants has enabled the analysis of health situation from other dimensions, including data of morbidity, disability, access to services, quality of care, living conditions and environmental factors. Considering health in this conception, health promotion and disease prevention as well as an inter-sectoral and interdisciplinary work, are strategies for their attainment[1]. The availability of information based on valid and reliable data is an essential condition for the objective analysis of the health situation, as well as for programming of health actions[3].

The implementation of the Unified Health System (UHS) brings, in its essence, an extension of the administrative autonomy of the municipality, historical struggle of managers, and the need for exercise of health planning[4]. The process of building information for planning gain importance, since between the principles of the Family

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Health Strategy (FHS) is "to develop activities in accordance with the planning and the programming carried out based on the situational diagnosis and focusing on the family and the community"[5:9].

The Nursing Course at the Federal University of Santa Maria (UFSM) develops activities in the FHS in the municipality of Santa Maria, Rio Grande do Sul (RS), integrating teams. For this reason, it is justified the need for unveiling the community constitution, its history and its socio-economic profile, so that enable the realization of health planning and the impact on local health indicators.

This article presents the results of research carried out in area of Family Health Unit (FHU) São José, located in Camobi neighborhood, whose research question was: which is the socioeconomic profile and how is this community formed? For this purpose, it was defined as objective to meet the socio-economic profile and the formation of the community, in order to subsidize the health planning.

MATERIALS AND METHODS

It is a descriptive qualitative research that used for the data collection, the Participatory Rapid Assessment (PRA). This method is employed to perform diagnostics of the health situation of population groups, based on the identification of relevant information that expose the real local conditions, from the own population. It is used as data sources existing records of primary and secondary sources, field observation and interviews with key-informants, intentionally selected as reference people of the community. On the observation field, the physical environment of the area, the resident profile, the types of public services offered and the attitudes of the informants during the interview are examined. Thereby, the PRA allows to evidence the problems that affect the population and its social, economic and environmental determinants[4].

The scenario of the research is the municipality of Santa Maria. It is located in the center of the State of Rio Grande do Sul and possessed in 2008, a population around 260 thousand inhabitants. The healthcare is conformed in health districts. The FHS was implemented in 2004, with the objective of supplying empty assistance with 16 minimum teams and five oral health teams, distributed in peripheral districts, serving a 23.84% coverage of the population of the municipality. The employment contract of the teams was outsourced. In 2008 the Community Health Agents (CHA) were public servants, but the rest of the team remained with provisional contract. The studied FHU has two areas, each consisting of six micro areas. In 2008 it had a registered population of 9,312 and 2,593 registered families. The team in the period of the research consisted of two nurses, two nursing technicians, two doctors, a dentist and a dental office.

The data collection occurred in the first half of 2008, using as data source observation field, key-informants interviews and document analysis. The interviews were conducted with 21 key-informants, among them eight residents, six CHA and seven other team members of FHU health. The information of the documentary analysis was primarily from religious institutions, health and education existing in the territory, as well as the Information System of the Basic Attention (ISBA). In addition to these data sources, the field observation was used. For that, during the interviews and the permanence of data collection places, such as FHU, the interviewees' residences, streets and community facilities there were observed the environment, the activities carried out by the people, in order to describe the context, as close as possible to reality. The observations were recorded in a field journal.

The data was analyzed through content analysis, thematic type[6]. In the presentation of the results, recorded in italic style letter, central ideas revealed in speeches, the identity of informants was protected by a code composed of one or two letters and a number, e.g., MO1. The letters MO, EA and E represent, respectively, the resident, the CHA and the health team of the searched area, and the number, which follows to the letter, identifies the order of realization of interviews per segment (MO1 the MO6, EA1 to EA6 and E1 to E7).

Respecting the ethical principles of research with humans, as the Resolution 196/96[7], a Free

and Informed Consent Form was read and given, in two copies, one for the researched and another for the researcher. The research project was reviewed and approved by the Research Ethics Committee of the institution to which the project is linked with the process number: 23081.007518/2008-82 and CAAE (Certificate of Introduction to Ethics Assessment): 0088.0.243.000-08.

RESULTS AND DISCUSSION

The results of the survey identified two themes: conformation of local realities and dimensions of social determinants of health.

CONFORMATION OF LOCAL REALITY: FORMATION, COMPOSITION AND AVAILABLE RESOURCES

According to the research data, initially the community of San José was a rural area, populated with the arrival of the Italian immigrant Luis Franciscatto, in 1875, which came on ship during the Italian immigration to Brazil.

Arriving to Santa Maria, Fransciscatto met Father Marcelino Bitencourt and began working as a sacristan. Subsequently he took his family from Italy, bringing with him the image of São José, his holy devotion. Arriving in Santa Maria, with the help of his family and with the support of Father Bitencourt, he built a small chapel, opened in 1885. Thus, the name of the chapel and the locality became São José.

From the perspective of the Italian immigrant, one of the fundamental values is the religiosity, in this case, represented by the Catholic Church. Thus, one of the first actions of the community was to build a chapel. For immigrants, the chapel was the symbol of pride and progress, the presence of the Father meant to guarantee growth for the community[8].

Over time, Franciscatto´s family was growing and the small community began taking larger proportions, making the locality most populous, arising the need for expansion of the chapel, a fact occurred in mid-1900 and later in 1949.

According to data found in the interviews, families who initiated the *urbanization* of São José neighborhood had a high socioeconomic level, subdivided small areas and built their own homes. This increase in population has generated demands of enterprise which complied with at least the basic needs of the people for the growth and development of the locality. So, in this historical period, it begins the process of urbanization, as it has occurred in most countries, even the industrialized[9].

Currently, it can be seen that the community is urban, counting also with a part considered rural, constituting a very extensive territory, divided into two areas, each with six micro areas. However even the urban area still preserves many rural aspects. To arrive at FUH, there is nearby, the presence of land destined for animal breeding.

The *religious beliefs* followed by residents are mostly Catholic and Evangelical that according to informants Evangelical is the predominant. In the community those beliefs also serve as space for health, constituting social networks of support for social issues.

> In relation to the Evangelical {Assemblies of God}, the cults have served also for space information in relation to the activities of FHU as well as guidance on matters of relevance to health. Moreover, in general the Ministers are leaders that serve as example and encouragement with others, teaching better ways of living (E4).

> The Catholic religion plays a very expressive role with the children through the Pastoral care. The team also works in partnership and in this space are held information, guidelines, monitoring of ponderal and nutritional development of them, and also from the provision of food, clothing and even multi-mixture (a food supplement for combating malnutrition) formulation for those with greatest need (E4).

There are still other institutions in the area of coverage of the São José FHU, founded more recently, which have social and health importance. It is exemplified with the Spiritist Society Light in the Way Dr. Fernando do Ó, created in 1992, which performs doctrinal work and study groups, in addition to meeting the children between 5 and 14 years old, with income per capita of up to 80 reais monthly, which study in public school, developing school reinforcement activities, computer classes, yoga and nutrition. The Authentic Mission Pentecostal Church, founded in 1998, located in a micro area of lower social group, aims to help those most in

need, preventing drug abuse and child prostitution. It idealizes also serve meals and evangelizes the population. It is funded by tithing and voluntary resources for the family's minister.

In relation to the *education network*, the location has a State school and two municipalities. There is also a daycare, which aims at giving support to mothers to carry out professional activities, increasing the family income and also providing a peaceful environment for the children. It is believed that today the population has enough vacancies to the demand of the community, as the line of the CHA and residents. However it is known that some micro areas are far from the schools of the locality, making students look for schools closest to their homes.

The presented report allows viewing the possibilities that are at the disposal of the teams for the development of intersectoral actions in the territory, since the social reality presents health problems mostly complex. The intersectoral approach is a way to overcome the fragmentation of public policies, breaking the limit of sector vision in search of building a communicative space that enables the resolution of complex problems[10].

DIMENSIONS OF SOCIAL DETERMINANTS OF HEALTH

The following dimensions are social determinants of health revealed in the survey, as well as the influence on health issues. Initially the environmental changes affecting the health-disease process of individuals are addressed, considering the discussion about health and environment interface in the indispensable basic attention.

With respect to water consumed by residents, most from the public supply system, provided by the Riograndense Sanitation Company (CORSAN), which may be evidenced by interviews and also by ISBA (93.71%). In some interviews, it was noted the presence of artesian wells, conventional wells and even the use of springs water for consumption. In these cases, water quality can be questionable, considering that they are not always carried out tests on the water.

> [...] in my area it has an artesian well, we're always driving to do test on water, on water quality (EA3).

> The water is polluted, totally polluted, bad odor, strong smell, a lot of mosquitoes [...] and I got tired of taking it to the Health Secretary (MO5).

The percentage of people without access to public water network is small. However, it is still not permissible the presence of non-potable water emphasizing the accountability of the City Manager. The issue of quality of water must be emphasized, not only due to the vector borne disease transmitters, but with an enlarged understanding of primary health care, including the environmental dimension in the process of health of individuals and communities, involving local environmental health promotion[11].

Another important issue concerns the problem of the fate of the *household waste*. According to ISBA data, the trash is collected by the city in 95.5% of the residences, however, for the interviews, some problems are listed.

> In relation to the garbage, there is collection, however the truck doesn't come close to some houses, missing a bit of community organizing to make that happen, or install a suitable container that can store the residues of several houses, until the collection is performed (E4).

> The trash is considerable, from regulate to good, we have the collecionts three times a week and when it is a problem the community itself participates in deliver the right things to put in the dumps (EA1).

By the reports, garbage collection is performed three times a week. The Government is appointed as responsible for substandard service in the face of not making the vehicle garbage collector can reach all the villas. However, residents are also indicated as a co-responsible for the problem.

The community under study has no *sewage network*, the disposal of human waste is done on septic tank and in some cases there is no destination, in this case the droppings are placed anywhere, and scattered by the rains.

> The sewer in my area has no treatment, on rainy days is horrible, there are floods that happens, people cry enough, that there is a bad smell (EA3).

> Sewer conditions here is the hole, there's even an open sewer, but is the hole, there passes an open sewer (MO4).

It is necessary to emphasize the accountability of the Government in the gaps of basic sanitation actions offer pointed out by the residents. In addition to the fact that the low population coverage of FHU and mapping, which still features health assistance, work on empty area of health as environmental field is a challenge. Such a challenge is the meaning of the term primary health care as a strategy for environmental action, based on prevention and participation at the local level. It recognizes the right of human beings to live in a healthy environment and to be informed about the impact of environmental problems on health, well-being and survival, as co-responsible in the protection, conservation and environmental recovery and health[11]. However it does not eliminate the State action to provide those obligations.

In the course of the survey, other dimensions of social determinants of health have been identified, such as the community literacy, socio-economic conditions, the source of income, the unemployment and the most widely used means of transport for residents.

As for the *literacy* rate, the information of the ISBA 96.32% of the peoples shows that over 15 years are literate. This data is relevant, because the level of education of the population is closely linked to health issues, manifesting itself in different ways, whether in perception of health problems, the ability of understanding of health information, in the adoption of healthy lifestyles, consumption and utilization of health services and on adherence to therapy procedures[2].

In relation to *socioeconomic* conditions, the community is also quite heterogeneous, there are people with high purchasing power, middle-class and other very poor, but the middle class predominates. The *revenue stream* is diversified, consistent with the heterogeneity of socioeconomic conditions. In the higher social group, the people are owners of companies, working in the provision of services or have formal employment in the lower social group, the predominant employment and informal activities. The constant growth of the informal sector is one of the important social and economic problems generated by the technological advances of our country, which moved from an agricultural economy to a mining and industrial economy, with emphasis on trade and service[2].

On the *income received*, we highlight that the informants responded not suffice to meet the basic needs in families of lower social group. This data was recorded in the accounts of four villagers, five CHA and all other members of the health team that took part in the research. The Bolsa Família Program has been cited as a way to supplement the income of the poorest families. This program has become one of the main instruments to combat hunger and guarantee of the human right to food in Brazil, and in many poor families of our country is the only way of obtaining a source of income[12].

According to 16 key informants, the community also has *unemployed* people, which remain predominantly through temporary and informal jobs. So, residents have no fixed job and income, which can have a negative effect on health issues. In this perspective, the research revealed that unemployment is associated with a worse health condition among adults. Formal workers have the best health indicators, individuals who are outside the labor market have worse health conditions and greater use of health services[13]. Thus, it is necessary to consider the situation of work as an aggravating factor to health inequalities.

The most widely used *means of transport* for residents of the community is the collective transportation (bus). The offer of the service depends on the location of the micro areas, those located near highways offer is unsatisfactory. In the micro areas further away from highways, residents find it difficult to use the service so they need to move a lot to get to bus stops, hindering the access of users to the FHU and children at schools.

The above findings on the provision of collective transportation added the fact the health team have mentioned that residents of the roundness of the FHU have better socioeconomic conditions, while the micro areas further away have low purchasing power. Heterogeneity occurs even within the majority of the micro areas. With this, it can be said that

some residents find difficulties regarding the accessibility to health services, due to geographical location and socio-economic conditions of some micro areas. Accessibility to health services considers the distance the user traverses to reach a gateway, network existing physical barriers, limits or amenities of locomotion and the costs involved in offset. For this reason, the access needs to be part of local health planning, in order to define actions that are consistent with the realities of the communities[15].

These socioeconomic disparities have influence on health issues, once that require a more elaborate health planning, recognizing people in all their vulnerabilities and needs. However it should be remembered that the uneven distribution seen here can be compared to that of our country, reflecting the logic that the general situation of health of a nation is not measured from its total wealth, but by the way it is distributed[2]. In this way, the planning and local programming shall provide for actions that contribute to change reality, fighting against the *status quo*.

However, for the achievement of viable and effective planning, it is imperative to come true intersectoral actions, led by the State, along with the professionals and users of the public health system of each locality, in order to enable the resolution of various issues that affect people's lives, in a manner consistent with its reality.

FINAL CONSIDERATIONS

The study conducted in the area of coverage of the FHU São José allowed knowing its origin, formation and current features with a view to health planning. The results presented here have revealed a singular territory, which is both complex and heterogeneous. It coexists with major socioeconomic disparities and also cultural, since the community was initially made rural urban, there is no more a predominant ethnicity, as in its beginnings. This dynamism and complexity should be taken into account in all actions in health developed there.

The use of the ISBA is demonstrated weak and insufficient for purposes of planning and decision making, presenting as important limitation of this research. Moreover, it can be stated that the team has a big challenge to exercise this office at FHU. Need to clarify that the municipality in question had not yet made public tender for the FHS teams. Thus, to be completed this research, the team, which was the subject of it, no longer works at the site, except for CHA, already gazetted. Therefore, it is expected that the results compiled assist the teams that are now assigned to the task, and further assume that space.

This research brings to light the implications of health planning in the community, as well as the challenges that teams of FHSs, not only of the territory, by developing its work in the basic attention. Thus, transforming the health practices in distinguished actions and committed to the principles and guidelines of UHS requires a deep knowledge workers of reality and an attitude implied.

CONSTITUIÇÃO E PERFIL DE UMA COMUNIDADE ATENDIDA POR ESTRATÉGIA DE SAÚDE DA FAMÍLIA

RESUMO

Objetivou-se conhecer o perfil socioeconômico e a formação da comunidade visando subsidiar o planejamento em saúde. Trata-se de uma pesquisa qualitativa e descritiva. Para a coleta de dados, utilizou-se a Estimativa Rápida Participativa e como fonte de dados observação de campo, entrevistas com informantes-chave e análise documental. Ocorreu em 2008, na área de abrangência da Unidade de Saúde da Família São José, do município de Santa Maria, Rio Grande do Sul. Os dados foram trabalhados por meio da análise de conteúdo. Os resultados da pesquisa descrevem a formação, constituição, recursos da comunidade e dimensões dos determinantes sociais da saúde. A conformação da comunidade revela um território singular, ao mesmo tempo complexo e heterogêneo, favorecendo a intersetorialidade. Os determinantes sociais da saúde encontrados permitiram identificar vulnerabilidades, grandes disparidades socioeconômicas e também culturais. Esse dinamismo e complexidade deveriam ser considerados em todas as ações em saúde ali desenvolvidas, principalmente no planejamento local.

Palavras-chave: Planejamento em saúde comunitária. Atenção primária à saúde. Sistema único de saúde. Enfermagem.

CONSTITUCIÓN Y PERFIL DE UNA COMUNIDAD ATENDIDA POR ESTRATÉGIA DE SALUD FAMILIAR

RESUMEN

El objetivo fue conocer el perfil socioeconómico y la formación de la comunidad pretendiendo auxiliar la planificación en salud. Se trata de una investigación cualitativa y descriptiva. Para la recolección de datos, se utilizó la Estimativa Rápida Participativa, utilizando como fuente de datos observación de campo, entrevistas con informaciones-clave y análisis documental. Ocurrió en el año 2008, en el área de la Unidad de Salud de la Familia São José, de la ciudad de Santa Maria, Rio Grande do Sul. Los datos fueron trabajados por medio del análisis de contenido. Los resultados de la investigación describen la formación, constitución, recursos de la comunidad y dimensiones de los determinantes sociales de la salud. La conformación de la comunidad revela un territorio singular, al mismo tiempo complejo y heterogéneo, favoreciendo la intersectorialidad. Los determinantes sociales de la salud encontrados permitieron identificar vulnerabilidad, grandes disparidades socioeconómicas y también culturales. Este dinamismo y complejidad deberían ser considerados en todas las acciones en salud allí desarrolladas, principalmente en la planificación local.

Palabras clave: Planificación en salud comunitaria. Atención primaria a la salud. Sistema único de salud. Enfermería.

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