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SOCIAL INCLUSION: THE PERCEPTION OF FAMILIES FROM A MUNICIPALITY OF WESTERN SANTA CATARINA[1]

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ABSTRACT
This study evaluated the perceptions of families in the acquisition phase about their social inclusion in the community where they live. A population-based survey was conducted with 101 families through home visits and the application of an instrument that included different variables referring to social inclusion. The interviews were conducted from July to September of 2012 in the city of Palmitos in Santa Catarina State. The cluster analysis was performed (grouping). The respondents rated as "good" and "regular" the issues that mediate the family perception of the exercise of citizenship. The perception of the support received from some social networks was "very good". The family income was the greatest reason of discontentment. As for health care, the ratings of the Basic Health Units was predominantly positive, unlike that about the Family Health Strategy, which was rated as underperforming. Basic sanitation issues also received a negative rating. Therefore, the importance of interdisciplinary work, joint effort of health professionals, and intersectionality with immediate action are fundamental to promote health and improve the quality of life of the population assisted.

Keywords: Primary Health Care. Family Relations. Family Health. Social Participation. Citizenship. Health Promotion.

INTRODUCTION

The family theme has been discussed for decades in the health sector, both in the health care setting and universities, especially after the implementation of the Family Health Strategy (ESF) by the Ministry of Health in much of the national territory[1].

Even if ESF teams still cannot manage their actions in a perspective that involves the family and the territory, and not just the individual, there is an effort of professionals committed to a more integral and civilhealth care towards investing in studies aboutthe family, observing their characteristics and singularities[1], in order to provide support to guide theprofessional practice in health care and other areas and the formulation of public policies[2].

Current studies show that the conceptions about health promotion refer to the natural history of the disease, with questions about it relatively lacking, including knowledge and discussions about the health-disease process, its determinants and the promotion of health in a vision based on the post-Ottawa Letter[3]. The question is: how do families perceive themselves in the process of social inclusion within their territory?

From this perspective, this research aimed to know the perceptions of families in the acquisition phase regarding their social inclusion in the community in which they live. The needs can be seen more clearlywith such studies making it possible to expand the coverage of public policies in the Primary Health Care.

METHODOLOGY

We developed a cross-sectional study with a population-based household survey, based on the Basic Care Information System (Siab)[4], to know the families' perception regarding social inclusion. The population surveyed was represented by 478 families in the acquisition phase, that is, with children up to nine years of age[5], living in the territory served by the ESF1, which encompasses the downtown of the city of Palmitos and two neighboring districts with a population of 3,955 people and ESF universal coverage.

The study complied withResolution 466/2012 of the National Health Council, which refers to research involvinghumans. All families were informed about the research objectives, guaranteed anonymity,and signed the Free and Informed Consent Form. The research was approved by the Research Ethics Committee of the University of Vale do Itajaí (Univali) underopinion number 115.222.

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The sample size would be of 120 families to guarantee a maximum error of 5% with a degree of confidence of 95%, ensuring estimators of studied parameters. However, even afterseveral drawingsconducted to minimize losses, it was possible to interview 101 families, which represented a loss of 16.7%; some individuals refused to respond the questionnaire and some households were not found.

The sampling plan was based on a stratified sampling with two selection stages as the primary units being the micro areas of ESF1 and the secondary units the households. The definition of families participating in the sample was determined by drawingsbased on the Siab Form A.

The challenge of assessing the social inclusion/exclusion from the perception of families required the elaboration of questions that focused on variables of various aspectsrelated to social inclusion and considering their influence on the families' daily lives[5]. Following this assumption, we used the Whitehead classification[6] that proposes levels of action that seek to combat health inequities, and constructs elaborated and validated by Dias[7], which guides the understanding of the existence of familyhealth as distinct from individual health. We organized the questionnairein themes, with open and closed questions, using questions already validated and based on the studies of these two authors.

The first part of the questionnaire contained open questions that dealt with household and interviewee identification data, which originated general information on family composition, income per capita, education, religion, race, work situation, and family trajectory in the community: time livingin the community, type of housing, and family networks and support.

The second part contained closed questions that included two major themes: individual (first level) and social and community networks (second level)[6]. The two thematic categories to measure these levels were selected according to the "Instrument for assessing the perception of families in the acquisition phase, regarding the social inclusion/exclusion criterion"[7]. The *Likert* type scale wasused to measure each of the constructs consideringfive response options: very good (VG), good (G), regular (R), bad (B), and very bad (VB).

The information was obtained by means of home interviews, with the application of questionnaireby interviewers, answered by the responsible personforthe selected families who was present at the moment of the interview. The interviews were carried out between July and September of 2012 by seven community health agents (ACS), who are employees of the Palmitos City Hall andwork on their respective micro-areas. These professionals were trained to begin the interviews with anemphasis on the accuracy of notes. During the period of data collection, repeated interviews were carried out to control and confirm data and to have secondmeetings with interviewers for the evaluation and clarification of doubts.

The analysis used in the first part was that of absolute and relative frequency and, in the second part, that of grouping or clustering, which seeks the geometric proximity between studied objects. The distances between such objects within themulti-plan space consist of axes forall variables, which are calculated to group objects according to their proximity.

Firstly, the two closest objects constitute an initial group, and subsequently,the next object is located closest to the center of the first group[8] until all studied objects are grouped.

The cluster analysis is used to identify groups of similar characteristics, that is, to categorize observations considering all the original measurements. The option for this multivariate method was based on the fact that the objective of the analysis was to verify similar groupings, without the concern of describing absolute and relative frequencies. It is important to examine the groupingscheme or dendrogramto arbitrate whatnumber of distinct groups can be obtained besides qualifying them according to the behavior of original variables.

After analyzing the data by the method described, the following thematic categories that defined the groupings were selected: 1. socioeconomic and quality of life with the formation of eight groups, which refers to the family nucleus and the social and community networks that are fundamental for the promotion and protection of individual and collective health; and 2. access to health and basic sanitation services with the formation of three groups.

RESULTS AND DISCUSSION

We observed that the majority of respondents are women (74.3%). With regard to education, 43.5%

have completed elementary education and 48.3% have completed secondary education. The family income ranges from one to three minimum wages (54.5%). Most families (59.4%) are homeowners and (33.7%) live in rented homes. Most families (28.7%) live in the community for more than oneyear, with a significant proportion of those living in the communityfor more than five years (61.3%).

The socioeconomic data found in the municipality of Palmitos are consistent with the profile of municipalities in the countrysideof the State of Santa Catarina, with its economy focused on family agriculture. The colonization of western Santa Catarina followed a small-scale model of theagrarian structure with its economy based on grain production and pig and poultry farming allowing the implantation and development of agro-industries[9]. The small-scale model of family agrarian structure explains the low per capita income and the low education levels.

In order to understand the first thematic category (graphs 1 and 2), it is fundamental to determine, among some principles, those that matter in the perception of what citizenshipis, here understood as the individual condition that indicates the belonging to a certain politically organized society, whose effect is to allow the enjoyment of civil, political, and social rights[10].

In this perspective, Group 1 - which includes the subcategories family members' knowledge about their right to have documents (DI2), family members' knowledge about their right to come and go (CD2), and freedom for family members to practice their religious beliefs (LR4) - was assessed with most of the answers as "good".

In Group 2 – the quality of family members' meals (QR3) and satisfaction of family members with the number of meals per day (NR3) -the rating"good" wasthe highest, however,the rating"very good" was the one that grows the most.

Group 3 maintains the rating as"good", however,the "very good" rating declines and the "regular" showsa small growth. This group includes family relationships with schools and health units (R4E), family relationships with friends, neighbors, and other groups (R4A), the family believes to live well in the community and in the home where they live (FB3), and the family's satisfaction with sidewalks, streets, roads, and bridges intheir community (SC4).

In group 4 - in general, howthe family evaluates their health (FA3), what kind of work family members perform (PC4), and the feeling of being part of the community (TT1) - the rating "good" showsa slight fall and the rating "very good" also falls while the rating "regular" and "bad" grow.

In Group 5 - the dwelling area (TM3) and the family dwelling (MO3) - the rating "good" is also maintained with the highest number of responses, however, the rating"regular" continues to grow and the "very good" falls. Group 6 showsthe same behavior, with responses presenting a higher number of "regular" ratingsin the subcategories: the family feels the same as other families in the community regarding their rights (IO2), sanitary installation intheir house (IS3), how the family considers that its community is integrated with other municipalities (ICS), participation of the family in the association of residents or similar in the community (AM2).

In Group 7 - freedom for the family to express their ideas and opinions in the community (LI2), freedom of family members to have a voice in the community (LV2), and access to work by family members (AT1) - the rating "regular" increases and the "good"decreases. In group 8 - family income to meet basic needs such as food, education, housing, health, and transportation (RF1) - the rating "good" is low and the rating "regular" is at its highest since the first group. The ratings "bad" and "very bad" start to grow as well.

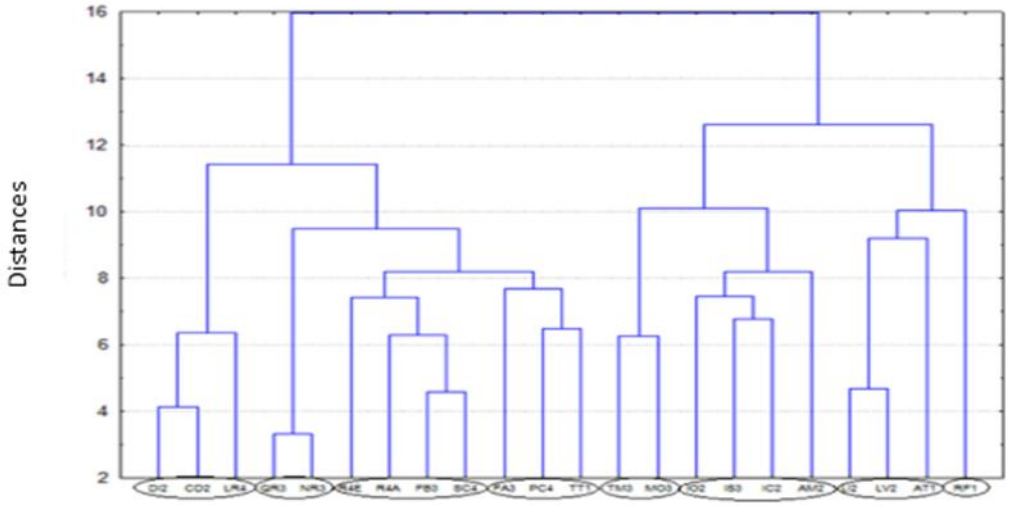
The predominance of the rating "good" in the first thematic category demonstrates the perception of the exercise of citizenship and human dignity - associated with the assumption that all members of a society are able "to participate in competition for life, or to achieve what is vitally mostsignificant, from equal positions"[11:31]–it is facilitated in the community in which families live.

Some constructs on which the rating "regular" has been growing are also concerned with citizenship issues. The idea of equality is resumed here and the assumption that the rights of some have to match those of others, because only then life can be understood in its full meaning - that of citizenship[12].

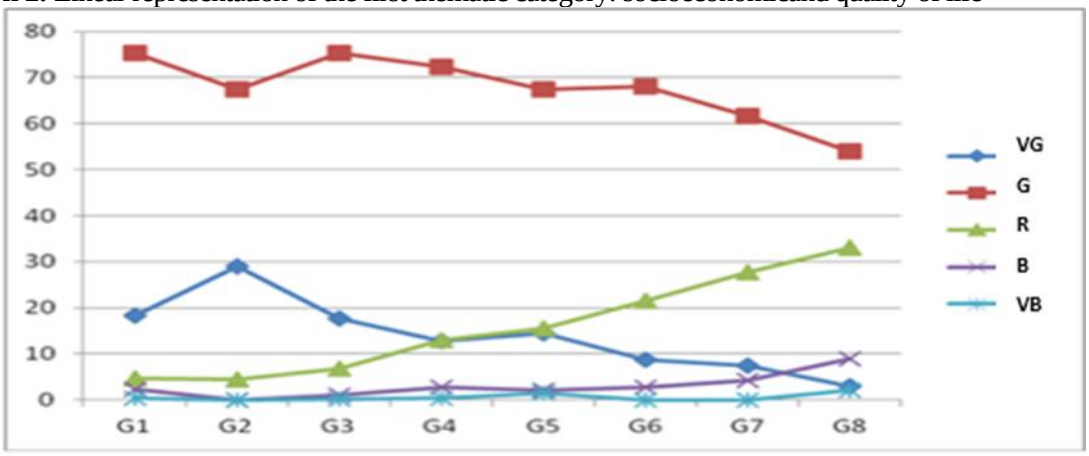
In the analysis of the social networks support subcategories, we consider that the process of living healthy is associated with people's unique way of life and their interactions, to the participation and involvement in community life, demonstrating that the understanding of healthy living goes far beyond

the causal determinisms of the health-disease process[13]. Therefore, the construction of knowledge about this phenomenon necessarily needs to consider the multiple dimensions and factors that involve daily living for each individual human being, inserted in their real and concrete context.

Graph 1. Dendrogram of the first thematic category: socioeconomicand quality of life



Graph 2: Linear representation of the first thematic category: socioeconomicand quality of life



The good performance of the families' perception of the support they receive from some social networks, family relationships with schools and health units, friends, neighbors, and other groups, and how the family believes to live in the community and at home is relevant to understand how the networks of relationships, exchanges, and obligations put forth by formal organizations are built and move in the community - schools, health services, pastoral - and informal ones such as family and neighbors[14] as well as the relationships of subjects and families with their social environment, which involves dynamic processes and continuous adaptations. Numerous resources are mobilized to meet the needs of daily reproduction and the arrangement of social networks is presented as one of the fundamental resources[15]. We consider that the absence of support from networks imposes limits on intervention programs because the family holdsmultiple arrangements that can make it very socially vulnerable if this support is absent.

The identification of social support networks makes it possible to use it as a resource in care, facilitating a partnership between the health team and the family to care for the suffering subject[16]. We infer that these constructs obtained a good ratingbecause, in a small municipality like Palmitos, the daily and prolonged coexistence,

mainly amongfriends, neighbors, and groups of relationship tends to favor the sharing of ideas, the exchange of experiences, and the strengthening of bonds of trust[17].

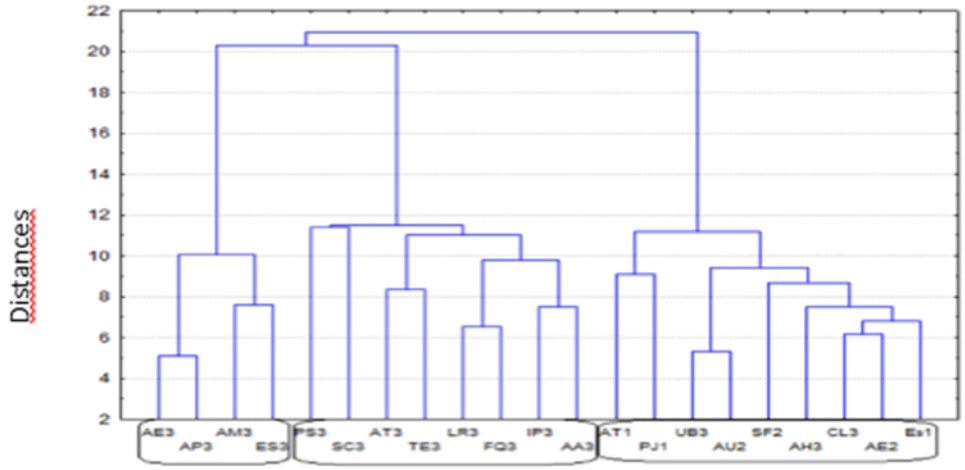
The thematic subcategory related to family in come satisfaction to meet basic needs such as food, education, housing, health, and transportation received the worst ratingand showed a behavior totally isolated from the other subcategories, that is, the families are very unhappy with their in come.

Among the reasons for these findings, we point out the poor distribution of capital goods, inflation, under employment, or unemployment. The extent of income inequality inevitably has repercussions on health and results from social stratification and political inequalities that surround the health system.

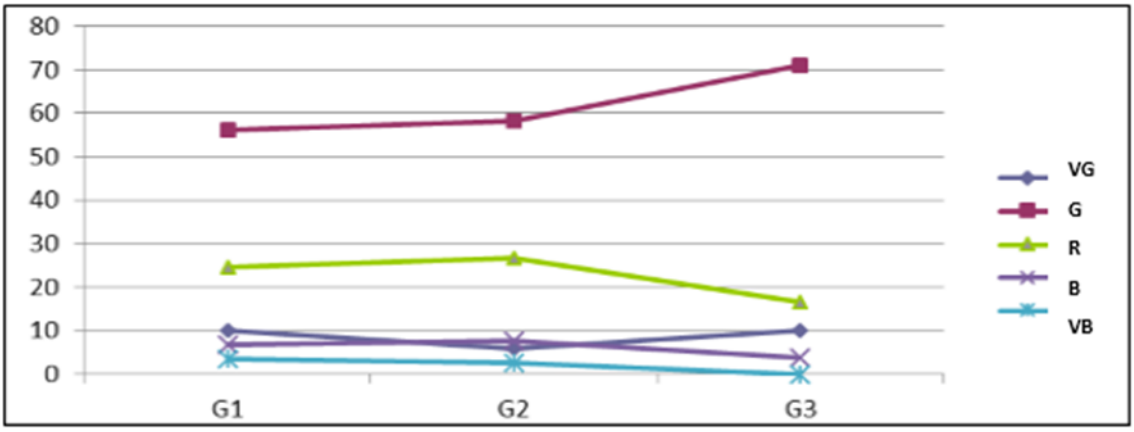
The perception of families in the second thematic category (charts 3 and 4) refers to the physical and psychosocial conditions in which people live and work, seeking to ensure better access to clean water, sewage, adequate housing, health services, education, and well-being, labor market, cultural values, and environmental protection[6].

In analyzing the subcategories related to equal access to health, we reinforce the idea that equality in this regard implies a fair distribution of services across the country based on health care needs, ease access in each geographical area, and removal of barriers to access[6].

Graph 3. Dendrogram of the second thematic category: access to health services and basic sanitation



Graph 4. Linear representation of the second thematic category: access to health services and basic sanitation



We verified the predominance of the rating "good" in Group 1,however,the rating "regular" was considerably high. This group includes the following subcategories: access to referrals for specialists(AE3), access to complementary exams (AP3), access to family medicine distribution (AM3), and access to ESF professionals (ES3).

We noted the approximation of the ratings

"good" and "regular" in Group 2 while the ratings "bad" and "very poor" grow considerably in all subcategories: community noise and environmental pollution (PS3), satisfaction with sidewalks, roads,and bridges in their community (SC3), access to public transportation (AT3), sewage treatment (TE3), street cleaning (LR3), water supply and quality (FG3), public lighting (IP3), and water supply (AA3).

With different performance, the rating "good" grows and the rating "regular" falls in Group 3, which includes the subcategories: access to work by family members (AT1), availability of parks, gardens, and recreation areas for the family (PJ1), access to the BasicHealth Unit (UB3), family members' access to the Health Unit (AU2), family security related to its members in the community life (SF2), hospital access (AH3), garbage collection (CL3), access to school (AE2), and school location (ES1).

We emphasize that municipalities are responsible for the comprehensive care ofusers, and therefore, knowledge about the use of services and health needs is of fundamental importance for managers[18]. It is interesting to note that the ratingsfrom respondents point to the need for improvements that must be implemented in the ESF assistance in addition to covering referrals for specialists and complementary exams.

The UBS care was positively rated. We understoodthat the UBS is working on the logic of accessibility to all who seek the health service and that it is necessary to strengthen the ESF actions with a view to welcoming and integrality towards the family and community, shifting the focused medical attention to the interdisciplinary team in order to incorporate a new way of thinking and act in the health of individuals, families, and community[18].

It is also fundamental to recognize groups with greater vulnerability to foster the development of educational and preventive actions for those health situations with greater demand for the services, identifying the excluded groups inthe system, and thus, attend to the initial premise of the SUS directed to the universality of access and care.

The lowest performing subcategories were those related to basic sanitation measures: noise and environmental pollution inthe community, satisfaction with sidewalks, streets, roads, and bridges in the community, sewage treatment, street cleaning, water supply and quality, and street lighting. The access to public transportation received the same rating. The garbage collection was the only construct of the basic sanitation measurementsthat received a positive rating.

The housing and sanitation conditions are very important issues in the formation of family health conditions and must be articulated with urban and regional development, housing, poverty alleviation, and environmental protection policies aimed at improving the quality of life[19].

FINAL CONSIDERATIONS

This study evidences, with positive results, the evaluation of respondents regarding their participation in the community, family knowledge on the fundamental rights and quality and satisfaction of meals that familymembers have per day. The results point to predominantly good and very good ratingsonthe support they receive from some social networks and family relationships with schools and health facilities, friends, neighbors, and other groups.

The constructs with the best ratingsin the area of access to health services were access to the UBS, access of family members to the Health Unit, and access to the hospital. Conversely, the family income satisfaction construct receivedthe worst rating, demonstrating the dissatisfaction of families with this item. The lowest ratings were related to basic sanitation measurementswith garbage collection being the only construct to receive a positive rating.

We emphasize the positive results related to access to work by family members, availability of parks, gardens, and recreation areas, thesafety of family members as to the life of its members in the community, family members' access to school, and location of the school.

Hence, it is fundamental to increase the interdisciplinary work, that is, the joint effortsofhealth professionals for health surveillance. The intersectionality, with immediate action, is also essential when it is intended to promote health and quality of life tothe assisted population.

INCLUSÃO SOCIAL: PERCEPÇÃO DAS FAMÍLIAS DE UM MUNICÍPIO DO OESTE DE SANTA CATARINA

RESUMO

O objetivo do estudo foi conhecer as percepções de famílias em fase de aquisição, quanto à sua inclusão social na comunidade em que vivem. Inquérito de base populacional com 101 famílias, por meio de visitas domiciliares e aplicação de um instrumento que contemplou variáveis de diversas naturezas quanto à inclusão social. As entrevistas foram realizadas no período de julho a setembro de 2012 no município de Palmitos, Santa Catarina. A análise foi de cluster (agrupamento). Os respondentes avaliaram como "boa" e "regular" as questões que mediam a percepção familiar sobre o exercício da cidadania. "Muito boa" foi a percepção sobre o apoio que recebem de algumas redes sociais. A renda familiar foi o maior motivo de descontentamento. Quanto aos serviços de saúde, a avaliação das Unidades Básicas de Saúde foi predominantemente positiva, ao contrário da Estratégia de Saúde da Família, avaliada com baixo desempenho. As questões de saneamento básico também receberam avaliação negativa. Diante dos resultados, deve-se considerar a importância do trabalho interdisciplinar, do esforço coletivo dos profissionais de saúde, da intersetorialidade, com ação imediata, fundamentais para promover a saúde e melhorar a qualidade de vida da população assistida.

Palavras-chave: Atenção Primária à Saúde. Relações Familiares. Saúde da Família. Participação Social. Cidadania. Promoção da Saúde.

INCLUSIÓN SOCIAL: LA PERCEPCIÓN DE LAS FAMILIAS DE UN MUNICIPIO DEL OESTE DE SANTA CATARINA, BRASIL

RESUMEN

El objetivo del estudio fue el de conocer las percepciones de familias en fase de adquisición, en cuanto a su inclusión social en la comunidad donde viven. Se realizó una encuesta de base poblacional con 101 familias a través de visitas domiciliarias y la aplicación de un instrumento que incluyó variables de distintas naturalezas en cuanto a la inclusión social. Las entrevistas fueron realizadas en el período de julio a septiembre de 2012 en la ciudad de Palmitos, Santa Catarina, Brasil. El análisis fue de Cluster (conglomerados). Los encuestados calificaron como "buena" y "regular" cuestiones que median la percepción familiar sobre el ejercicio de la ciudadanía. "Muy buena" fue la percepción sobre el apoyo que reciben de algunas redes sociales. El ingreso familiar fue el mayor motivo de descontento. En cuanto a los servicios de salud, la evaluación de las Unidades Básicas de Salud fue predominantemente positiva, a diferencia de la Estrategia de Salud de la Familia, evaluada con bajo rendimiento. Problemas de saneamiento básicos también recibieron una evaluación negativa. Con base en los resultados, hay que considerar la importancia del trabajo interdisciplinario, el esfuerzo conjunto de los profesionales de la salud, la intersectorialidad, con una acción inmediata, fundamentales para promover la salud y mejorar la calidad de vida de la población asistida.

Palabras clave: Atención Primaria a la Salud. Relaciones Familiares. Salud de la Familia. Participación Social. Ciudadanía. Promoción de la Salud.

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