Experiences in the Family Health Strategy: demands and vulnerabilities in the territory

Vivências na Estratégia Saúde da Família: demandas e vulnerabilidades no território

Vivencias en la Estrategia de Salud Familiar: demandas y vulnerabilidades en la comunidad

Antonio Germane Alves Pinto[I]**, Maria Salete Bessa Jorge**[II]**, Mirna Neyara Alexandre de Sá Barreto Marinho**[III]**,
Emery Ciana Figueirêdo Vidal**[I]**, Priscila de Souza Aquino**[IV]**, Eglídia Carla Figueirêdo Vidal**[I]

[I] *Universidade Regional do Cariri, Department of Nursing. Crato, Ceará, Brazil.*
[II] *Universidade Estadual do Ceará, Postgraduate Program in Public Health. Fortaleza, Ceará, Brazil.*
[III] *Government of the State of Ceará, Secretariat of Health, Center for Hematology and Hemotherapy. Crato, Ceará, Brazil.*
[IV] *Universidade Federal do Ceará, Department of Nursing, Postgraduate Program in Nursing. Fortaleza, Ceará, Brazil.*

ABSTRACT

Objective: To understand the daily demands of Family Health Strategy in clinical practice of the team and social vulnerabilities of community territory. **Method:** Research with qualitative approach, in a critical-reflexive perspective, held with two teams of the Family Health Strategy, in the city of Fortaleza, State of Ceará, Brazil. The participants were 22 users and 19 health professionals from the basic health network. Data from the interviews and observation were analyzed under the assumptions of critical hermeneutics. **Results:** We highlight the unveiling of sufferings and daily clashes, the influence of social determinants on health and psychosocial demands, limits and possibilities of everyday clinical practice. **Conclusion:** The clinic attention must recognize the perceptions and living conditions by listening and promoting health in the community.
Descriptors: Family Health Strategy; Social Vulnerability; Social Determinants of Health; Health Systems; Public Health.

RESUMO

Objetivo: Compreender as demandas cotidianas da Estratégia Saúde da Família na prática clínica da equipe e as vulnerabilidades sociais do território comunitário. **Método:** Pesquisa com abordagem qualitativa, numa perspectiva crítico-reflexiva, realizada com duas equipes da Estratégia Saúde da Família, no município de Fortaleza, Estado do Ceará, Brasil. Os participantes foram 22 usuários e 19 profissionais de saúde da rede básica de saúde. Os dados das entrevistas e observação foram analisados sob os pressupostos da hermenêutica crítica. **Resultados:** Evidenciam-se o desvelamento de sofrimentos e enfrentamentos cotidianos, a influência dos determinantes sociais na saúde e as demandas psicossociais, limites e possibilidades da prática clínica cotidiana. **Conclusão:** Considera-se que a atenção clínica deve reconhecer as percepções e condições de vida pela escuta e ações de promoção de saúde na comunidade.
Descritores: Estratégia Saúde da Família; Vulnerabilidade Social; Determinantes Sociais da Saúde; Sistemas de Saúde; Saúde Pública.

RESUMEN

Objetivo: Conocer las demandas diarias de la Estrategia de Salud Familiar en la práctica clínica del personal y las vulnerabilidades sociales en la comunidad. **Método:** Estudio cualitativo, bajo la perspectiva crítica y reflexiva, realizado con dos personales de la Estrategia de Salud Familiar en la municipalidad de Fortaleza, Brasil. Los participantes fueron 22 usuarios y 19 profesionales de salud en la red básica de salud. Tanto los datos de las entrevistas como los de la observación se los evaluaron bajo la hermenéutica crítica. **Resultados:** Fueron manifestados sufrimientos y enfrentamientos diarios, así como la influencia de los determinantes sociales en la salud y las demandas psicosociales, los límites y las posibilidades en la práctica clínica diaria.

Conclusión: El cuidado clínico debe reconocer las percepciones y las condiciones de vida a través de la escucha y de acciones que promocionen la salud en la comunidad.

Descriptores: Estrategia de Salud Familiar; Vulnerabilidad Social; Determinantes Sociales de Salud; Sistemas de Salud; Salud Pública.

CORRESPONDING AUTHOR   Eglídia Carla Figueirêdo Vidal   E-mail: eglidiavidal@hotmail.com

INTRODUCTION

The construction of the Unified Health System (SUS) represents a collective initiative to consolidate a model of public services for the people in the territory. In this way, it planschanges in the health care of the population with a sense of ethics and a civil sense for all activities. Continuously, it intends to reverse a healthcare model based on cure for a preventive perspective and promoter of health, giving priority to the demands of the territory in line with the challenges of the system.

The first International Conference on Health Promotion held in Ottawa, Canada, in 1986, brings up the need for some fundamental factors for obtaining health, interwoven in the social issues that reflect in the way that citizens and governors think on it and on resources available for its range. The situation of health promotion goes beyond its sole responsibility of the health sector to a collective and social dimension. It is a process that empowers communities to a more active participation of citizens with greater control over their health and considers the identification of their aspirations so as to satisfy their needs and even favorably modifying their social and environmental surroundings[1].

In this perspective, primary health care in the Brazilian context is determined by the society in their way of living and is related to the social context, integrating the construction of health policies, by promoting human life, therefore, permeated by the full social life.

The Family Health Strategy (FHS) covers a reorientation of practices in this context, which is structured since the performance of multi-professional teams in a given territory developing actions from the knowledge and experiences of local reality and the needs of the community[2].

Thus, it becomes a priority to recognize the territory as a social space where society builds itself and reconstructs itself, at the heart of its working process and production; dividing itself in different classes with unequal access to consumer goods, including health services[3].

The action of the FHS professionals comprises a range of skills to handle the dynamics observed and experienced in the territory. There are many experienced dilemmas and numerous vulnerabilities that require understanding, monitoring and coordination with other sectors for reaching health promotion.

Extending that thought, territory is considered a geographical space with extensive features, which permeate social, political, geographic, demographic and epidemiological aspects, in a live and permanent building, so that the various actors involved in this scenario are faced with health needs for which the provision of services is somewhat insufficient, because the existing demands exceed the limits of the sector, which implies a work involving joint action and integrated intersectorally[4].

Care in the primary health care addresses situations of illness, vulnerabilities and risks; it requires from the professionals a performance based on users' autonomy, understanding its insertion in a social and cultural context. Thinking from this perspective requires a differentiated look at health care, understood as live work, within which are analyze the different and complex existing demands in the territory and the health unit is accepted as a listening and intervention space, prioritizing the health care needs[5].

From these questions and reflections, the objective of this research is to understand the daily demands of the Family Health Strategy (FHS) in clinical practice and social vulnerabilities of the urban community territory.

METHOD

Ethical aspects

The research served the devices and guidelines regarding studies conducted with humans, according to the principles of bioethics of the Research Ethics Committee (CEP) of the State University of Ceará (UECE).

Type of study

Research with qualitative approach, critical-reflexive perspective. Understanding of reality emerges from the critical analysis of the processes, structures, perceptions, products and results in articulating the vision of the social actors with the possibility of transformation of their contexts[6].

Methodological procedures

Study scenario

The research was held at Fortaleza, capital of Ceará, with two active teams in the *Secretarias Executivas Regionais* (Regional Executive Offices – SER) IV and V. This choice is justified by the institutional agreement of the State University of Ceará (UECE) with the Municipal Health-School System of the Municipal Health Secretariat of Fortaleza in developing studies, research and permanent education partnerships in these areas. The choice of these units was bounded by the local management of health districts, and the option for the team occurred by complete composition of its members. Health units were selected by drawing on the regional health coordination of the city.

Data source

Participants were composed of 22 users and 19 healthcare professionals operating in the territory of the FHS, being three doctors, two nurses, three nursing technicians and 11 community health agents. Health professionals were selected for acting in the territory and team actions of the FHS; and the users,

those who kept active registration in the health unit. For this thematic approach, the final composition of 41 participants was based on theoretical saturation, which occurs in qualitative research when, in the relationship between the researcher and the field, the researcher realizes the absence of elements that lead or deepen his theorizing, considering the material available[7].

Collection and organization of data

Data were collected in the period from April 2011 to January 2012, and, in its course, it was used the semi-structured interview techniques and systematic observation. We approached the participants with formal authorization and coexistence in daily life assistance. The point that conducted the interview was the relationship between the FHS and the team with users, mutually. Specifically, we guided questions about everyday demands, communitarian clashes and health practices. The observation briefing contained points related to difficulties and facilities of FHS, and, in a field journal, it were recorded observations and impressions of the researchers. The interviews had electronic recording audio and had an average duration of 20 minutes. In observing systematically, it was possible to experience the relationship between participants in the reception areas of the units, in individual consultations, in health education groups and even in the event of home visits.

Data analysis

Data were analyzed under the assumptions of hermeneutical critique[6]. After the organization and classification of speeches – through the steps of exhaustive and floating reading of the material collected in the interviews and observations; transversal reading of structured communication from the nuclei of meaning; and the final analysis; performed manually and argumentatively –, there was the thematic categorisation, with emergence of five categories, namely: A silenced suffering: "auscultation or listening?"; Population densification and the influence of social determinants for health of the community; Violence; Psychosocial demands; and Everyday clinic.

In the preparation of this manuscript, it were considered the criteria for reporting of qualitative studies, present in checklist COREQ – Consolidated criteria for reporting qualitative research[8].

RESULTS

The following categories are highlighted according to the determinant meanings in lines of the participants and findings of the systematic observation, that allowed *in loco* analysis of the daily life of users and professionals. Speeches are identified with the representative group and the sex of participants, numbered only for differentiation in this empirical frame.

A silenced suffering: "auscultation or listening?"

In the context of the clinic of the FHS, there is a constant search for concrete results in its operating process on the part of professionals, glimpsing the possibility to minimize or extinguish some evils that permeate the lives of users and families. In consultations, it generally occurs the anamnesis,

characterized by the interview and physical examination, in which it seeks for a diagnostic finding, a conclusive scenario of problematic situations.

The following reports highlight users' perceptions about the problem of an unqualified listening on FHS, which would eventually affect health care:

> *My case is very complicated. If I don't treat it, I'm going to die. Because in this world, it's every man for himself. The difficulty that we find in SUS is the lack of attention. The person attends you and don't even look at you. My problem is serious!* (User 1)

> *It's too many people, there's not even time for the doctor to look us up.* (User 2)

The communication process, listening, observation and interaction were considered fundamental to the process of work on FHS, with guidance for the understanding of local problems. One of the doctors that participated in the study highlighted this theme:

> *To work on the Family Health Strategy what is most important is looking at the patient, listening, understanding and trying to do everything possible. For that, the medical specialty is not important in the resolution. What is more important in the clinic of the FHS is the look as a whole. Only in this way it is possible to find appropriate solutions.* (Doctor 1)

> *There are things that the stethoscope doesn't auscultate.* (Doctor 2)

The daily work of the clinic in urban areas acquires sensitivity to a greater understanding of the socio-communitarian situations. However, it is known that the barriers faced by these professionals in the labor of their performance are still numerous and challenging.

Population densification and the influence of social determinants for health of the community.

Fortaleza, home of our study, being the fifth most populous municipality in Brazil, presents complex problems that challenge existing policies and the structure of the services. The capital is completely urbanized, so that its rapid population growth and spatial expansion happen without considering the environmental system on which it is structured, generating, consequently, several social and environmental damages.

Professionals and users understand this dynamic, as the lines point out:

> *When I first came here it was just backwoods. Look how many houses there are now. And more are coming every day. And if it was just that. People come from all over the place. It's so many people that we don't even know who they are. God only knows* [Expression of mistrust]. (User 3)

> *Sometimes you can't even find out what people have. We do know, but we have our limits in taking care of everything. There's a lot of poverty in the midst of the world. It's our everyday reality.* (Doctor 3)

Thinking, therefore, about the work process of the FHS to consider the aspects mentioned, population health and its determinants factors are tied to the local context.

Violence

In the analyzed context, the actions directed to reduce the crime rate involve the shallow demand control of occurrences through cars, blockades and search for weapons or any objects related to infractions. During the day, there are several points of agglomeration of adolescents, young people and adults ingesting alcohol or providing some contact between partners.

Among the sayings in the speeches and the silences in the observations, it adds the regency of movement in areas delimited for the drug "market." In home visit, dialogue, investigation and even the recorder of the research intended the domestic environment to avoid the flow of buying and selling of the substances possibly marketed there:

> [When] *we go in this health center there, do you know how it's done? A gathering. The women gather themselves on the day of the consultation, then we all go together in the early hours of the morning, because if we go alone, you run the risk of dying, of being raped, of being killed, of running on an accident. When the husband's home he'll get us there. Yes, it's sad, the health center in a no man's land and we take that risk.* (User 4)

> *Just walk into a house after the excusing yourself to the head of the local place. Cordially and even in a friendly manner I was allowed to walk through that area along with the Community Health Agent. "Let everything here, it's not good to take anything of value" he said just outside. It's a place like any other. Only with a different logic of coexistence and a potential risk for criminal actions. For those who live in the community and maintains the system, no difficulty is enforced. Just the silence.* (Note)

The area where the research was held coincides with *Território da Paz* (Peace Territory), which is a program of the Federal Government to carry out integrated actions to combat violence and promote community peace. For keeping a big territorial extension, the activities performed are still centered on social interaction devices installed in most central neighborhoods in the region. The complexity of the vulnerable space allows micro areas further away being excluded from such socialization mechanisms.

The health district, the neighborhood, the community are organizational attributes that transpose the meaning symbolism for those who experience this reality, in which social determinants support the confluence of vulnerability:

> *You see where we live? What is this place? On paper, it is very beautiful. To say you have so many people. That this area is yours. That you have to solve this and that. But come here. Come and see the reality. Come ask permission to circulate here. Talk is cheap. Living is hard.* (User 5)

> *I can't even tell where I live when I'm in another corner. Some people are afraid when I say I'm from here. We do*

not live, we hide. But it shouldn't be like that. There's a lot of good people here. Not everyone is dangerous. (User 6)

With that being said, community spaces have representative influence in the congregation of senses and meanings in the life of the population.

Impositions of criminality conform the distinctive way of life where people remain hostages in their own homes and/or market:

> *It's like this that you're seeing now. The "bodega"* [small grocery store] *is all barred. It is the fear of being robbed. Everyone is afraid.* (User 7)

> *I am from the time that we could chat on the sidewalk. We can no longer do that. I only chat indoors.* (User 8)

> *The church is the only place that we meet. Other than that, we don't even see people's faces.* (User 9)

> *Sleep is the best you can do, because there isn't a leisure area for children, there isn't a health post, there isn't basic sanitation, there's nothing, there's nothing here.* (User 5)

Psychosocial demands

The FHS team expressed that psychosocial demands are common situations among those who come to the health service:

> *More than half of the clinical problems that I attend come with a situation of mental conflict. It's like we have a CAPS* [Pyschosocial Support Center] *inside the health center. It's all about the look of the clinic, one must understand the patients to figure out the best therapeutic conduct for them.* (Doctor 2)

> *We have a very big demand of people with disorders, taking controlled substances and who also have high blood pressure, recurring pain that we've already know on account of life's afflictions.* (Nurse 1)

> *There are people who look for the health center as a way of relieving so much suffering.* (ACS 1)

The capillarity of primary health actions must be in the dept of community life. Episodes of social tension that generate crime, mortality and the differences in the process health-physical and mental disease are situations that compose the life of the territory and require attention and care.

Everyday clinic

The damage to physical health associated with chronic illness situations with the excessive and problematic use of alcohol and tobacco manifests itself significantly in comments and narratives of the team and users:

> *There are a lot of people in those bars that drink to kill time. They don't have anymore hope of life. They're killing themselves slowly.* (User 10)

In a concomitant sense, the actions aimed at the monitoring and treatment of people with chemical dependency starts in primary health care. Psychosocial imbalance conditions

have a direct relation with the adoption of immediate measures for the relief of pain or suffering, be that relational, psychoemotive and behavioral disorders, i.e., the abuse of drugs. The following are reports of users:

> There are some people that open the lid of the cesspits to hide drugs. Then, the pits are all open. They take the pipes of the houses. They open everything, from the bridge to the avenue. They've filled with light poles, it looks nice. But who passes on the avenue up there thinks it's all open and peaceful. But, actually, it's too dangerous, every night there is a lot of bums in the bridge. Where we live is dangerous, every thief and scum it's all there. And with a lot of shooting. (User 11)

The continuous reshaping of care formats goes through the awareness of the limitations and possibilities of each team member. Prevalent occurrence of people converges with disorders caused by chemical dependency; however, the solution must be shared between the team and the other equipment of society in the territory.

> Do you think I didn't try to talk to these young people to avoid drugs? Look here how many books, CDs and DVDs that I have. I try, but nobody knows what is going out in the morning and being approached by an owner of drug den [drug sale site] saying that he wants to know why I'm 'busting' [making it hard] his business, no. (ACS2)

It is clear the condition of community residents in experiencing the same risk of crime, among other instances against life (their own and of their family).

DISCUSSION

The physical exam starts from subjectivity, based on the health history of the individual, facilitating the location of affected organs (or not) due to any pathology, with need for interpersonal relationship, with humanistic, ethical and social aspects[9].

In the FHS, there is a problem that undoubtedly undermines this listening more attentively: time, sharp demand and sometimes lack of sensitivity to the work performed, resulting in a listening conduct merely prescriptive for social complaints[10].

The act of listening to the user in a health service represents the opportunity to express their complaints even if these are unattractive to the diagnostic process or treatment hegemonically established. Through listening, trust in the professional worker is increased, triggering a timely communication or unsatisfying those who feel distanced in this relationship[11].

Thus, the communication process, listening, observation and interaction are fundamental, being essential also the internal availability of the employee, oriented by a concrete interest[12].

Conversations in a clinical interview aim a meaning, a demonstration of interest between professionals and users[13]. Speeches of health professionals should prevent conversations emptied of meaning, motivated by repetition and/or reproduction of practices of assistance productivity, disregarding the local context, the real suffering and the hope of life of people in the community.

To do so, we noticed that silence converges in this space. There are times in which the expression of the experienced situation is blocked by reflection and the singular sensation of daily clashes, of personal victories and of effort to survive in multiple, differentiated and, almost always, excluding spaces of that which could promote life.

There are what enables this coexistence on the threshold of necessity, an alternative path, a trail and even an inertia for reality transformation. The territory becomes vivid and active in the confluence of these paths, and the clinical sensitivity should transpose the detection and monitoring in order to advance in sharing possibilities, actual and appropriate to the social life of the individuals.

As for the aspects related to population densification, geotemporal and socio-historical transition of communities accumulate peculiarities of population movement process, with differentiated perspectives from the condition of sociability of every individual, family, or grouping[14]. Therefore, there are the common tensions of urban settings in contemporary times.

In this sense, the growth/population densification follows the social and environmental vulnerability, understood as the overlapping of social and environmental issues and risks, which are concentrated in certain areas and extend the poverty and other ills, existing in many peripheral areas and peri-urban areas, aggravated by exposure to the risks or for some issues of environmental degradation[15].

The source of the problem stands out from population growth and widens in harmful exposure by risks of transformation from urban development in an naturally fragile environment[16]. Therefore, the demographic factor presents a dual role, considering the prospect that the individual is able to influence the environment and receive influences from it.

We understand, then, as social determinants of health (SDH) those interwoven to individual behavior and living and working conditions in a macrostructural dynamic that permeates economic, social and cultural aspects, being, therefore, the resulting products of human action and possible to be modified and transformed by this action[17].

The high population density in the peripheral areas of large urban centers is directly related to health care. Assistance formats and even priority mechanisms of reversing the logic of care and health promotion in the territory, following the example of FHS, must have innovations in the operating process to consider the offer-demand-care relationship[18].

The social process converges accommodations in the unique dimension of users that lead them to take personal steps to live in the big city. However, it is necessary to distinguish the connection between being under pressure of situations of violence and having a social disadvantaged condition.

It is a fact that the condition of misery exempts the walk aimed at the practices of drug trafficking or criminal events. However, the recurrent exclusion of opportunities for maintenance of life provides an opening more accessible to deepen in life situations involving crime and chemical dependency[19].

In 2009, the interministerial initiatives between the spheres of government have deployed the "Peace Territories," and the sites chosen must articulate social actions (education, social action, culture, art and leisure), of urban recovery and justice

and security, aiming to eliminate areas of social vulnerability and potential risk of crime[20].

In the health area, social determinants support the confluence of vulnerability, expressing multidimensional values – biological, existential and social; point out the divergent causalities for the scenario of community life, restricting relational capabilities of affirmation in the world, generators of weaknesses[21].

Social identity conforms by place of life and relational existence of people. The remission of these belonging feelings comes from the absence of free movement in the streets, squares and places in the neighborhood. Leisure is hostage of insecurity, and the worst tension becomes the domestic imprisonment[22].

The operation of the clinic in the FHS needs to recognize this dynamic of urban life to understand the attitudes of users against the mechanisms of care, healing and health promotion. Community is more symbolic, more managerial than real. If the person keeps the coexistence between continuous tensions and reduces its threshold of social interaction, it is possible that he/she develops, over time, undesirable occurrences for personal health[23].

It is the socio-affective loss that most destabilizes community life. Situations of continuous uneasiness or momentary tension make people feel unprotected and dissociated of the coexistence among neighbors.

Social mobilization equipment seek to encourage interaction between people to promote the culture of peace in society. Peacemaking strategies focus on the social living through dialogue and exchange of experiences among community members. The foundation for community integration initiatives is based on solidarity and on the share of possible solutions[20].

The determinants indicate a life relieved of basic supplies and relationships based on subordination by violence, by power or social inequality. The growth of urban communities is associated with the addition of troubles that motivate the irregular and unjust development.

Demands in the field of mental health focus on healthcare network transversely, which sometimes cannot handle its particularities. These are situations with mild or moderate severity that are usually associated with morbid aggravations prevalent in adults and older people. The symptoms of depression and mild anxiety are the most common complaints encountered in basic health units, especially amongst women giving treatment based on the use of anxiolytic[23-24].

It is in these situations that the clinic multiplies itself in various strands. It is impossible to follow a single trajectory to enable outputs in conjunction with the users and their psychosocial demands. The maintenance of medication conducts for superficial relief only imbues more the remission of those individuals towards their own life and struggles. Here is the necessary innovation: to look beyond the body and mind, recognizing also a subject in their social path.

The finitude of human life is a natural condition of the body's physiology. However, access to care devices is part of the universal responsibility towards human beings and the listening to their problems[25]. In the disregard and the very personal and unique limitation to seek a horizon that harmonize life with health, kids, young people, adults, men and women are wiped out for the harvest of the sick and of chemical dependency.

The actions of health education and health promotion are maintained in such a way that, over time, they show positive and welcomed results into the behavior of the population[26]. The national policy of primary health care emphasizes participatory education and shared creativity for learning and taking precaution for reducing risks and damage to life[27].

Similar paths could comprise, on the daily life of the territory, activities aimed at environmental awareness, garbage collection, among others. The diseases prevalent in the community have close relationship with life and actions towards the environment. Community spaces feature niches of contamination due to aggressive practices towards the nature and the ecosystem.

The community is important for public policies of confronting the emerging situations of indiscriminate use of crack cocaine as well as for clinical practice focused on the consequences and approaches in the psychosocial field[28].

In the researcher's perspective, there is a sense assigned to the FHS as responsible for the insertion of the primary actions in the community together with other intersectoral devices. The complexity of contemporary social problems requires the versatility of the "all at once," within which we must educate, control and monitor to enable the integrality of the care and life.

However, there are distinctions between all situations experienced in this tense and dynamic daily routine. The guidelines on healthy eating and the limitation to the use of hyperlipidic products or with salt (sodium) differ from the preventive approaches to the use of marijuana, crack or cocaine. Nevertheless, all activities are necessary and are prevalent throughout the community territory.

Limitations of the study

The limitations of this study must be highlighted, given the impossibility of generalizations of the results, considering the regional limits of the research and the specific area of analysis. However, the singularities highlighted by different social actors in the reality of the family health strategy show us a rich universe of possibilities to understand the daily demands of the Family Health Strategy in clinical practice of the team around the social vulnerabilities that surrounds this community territory.

Contributions to the area of health, nursing or public policy

The study shows contributions to health care and nursing regarding the need to look at the territory of care in FHS, lacking devices that expose its operation, question its logic and constitute symbolic field to redefine its meaning in the daily practices of the care. This way, it enables the construction of new health practices, in terms of perception of other ways to work and care, before the unveiling of sufferings and daily confrontations, where clinical attention recognizes those limits and conditions of life for breaking with the established mode of intervening on the health territory, empowering health promotion actions in the community.

FINAL CONSIDERATIONS

In the living territory, it is possible to know the limitations and overcomings of clinical care in health. Chronic and psychosocial

illness reveals different needs of the population. We must practice a clinic that instrumentalize itself for the process of care and healthy living recognizing the power of intersubjectivity. The look on the body, the listening of the other and the underlying living conditions becomes transversal in assistance practice and must permeate broad health promotion actions in the community.

In community relations, the social dimension of the life of the users emerges, which is the experienced way of life. It is in the construction of social ties, in facing environmental adversities and in recognizing the vulnerabilities and risks in the community context that the clinical attention can absorb and share potential elements for care integrality. The urban context requires the incorporation of its features, streams and movements in the fair programming and implementation, integral and universal of the SUS.

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