



## **Quick participatory estimation: a necessary tool for planning in a family health strategy**

### **Estimativa rápida participativa: ferramenta necessária para o planejamento em uma estratégia de saúde de família**

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### **ABSTRACT**

**Introduction:** Participatory Rapid Estimation (PRE) is a tool that allows us to know the real needs of the population, as well as to experience the health situation. In addition, it makes it possible to identify and seek the necessary changes in the work processes of the territory to face problems. **Objective:** To obtain a situational diagnosis of the area covered by the family health strategy based on the ERP. **Methodology:** The information for the ERP was collected by filling out a questionnaire answered by users and health staff with questions about the community, health problems and the functioning of health services, including access and work process. Secondary sociodemographic data from the municipal database and the Ministry of Health's e-SUS medical record were also analyzed. The systematization of the data supported the elaboration of the situational strategic planning (PES). **Results and Discussion:** Several weaknesses were found, such as the geography of the area being predominated by hills, pointed out as a limiting factor to access to the ESF, the increase in the incidence of mental disorders in adolescents and the significant increase in users with NCDs and neoplasms in adults and the elderly, including the distribution of age groups in the territory signaling a reality not found nationally, as it presents an inverse pyramid showing that most of our users are elderly and adults. In addition to difficulties in the work process, there was also a lack of information on gender and sexual orientation issues for the lesbian, gay, bisexual, transsexual and transgender, queer, intersex, asexual and other (LGBTQIA+) population,



which should be questioned during user registration. Knowing that the lack of data collection implies the estimation of this population in the face of public policies, it is necessary to overcome this flaw through permanent education with CHWs. The social vulnerabilities of the community are notorious (unemployment, food quality and access to medications outside the SUS). Final Considerations: Based on the ERP, we recognized the territory's coverage area, as well as identified organizational problems, user access and actions that can be enhanced in the ESF's area of activity.

**Keywords:** Public health, Collective health, Public health practice, Health planning, Community participation.

## 1 INTRODUCTION

Participatory Rapid Estimation (ERP) was used because it is a tool that allows collecting information with the team and community, knowing the real needs of the enrolled population, as well as experiencing the health situation, identifying and seeking solutions and replanning the work processes of the territory. The study involved questions about the community, identification of diseases and health services, including access and work process of the unit and the use of sociodemographic data from the electronic medical record system and e-SUS database, territorialization data and field observation. The data collected were systematized and distributed in tables, graphs and images and later presented at a team meeting. From these, the weaknesses were identified, and the situational strategic planning (PES) was elaborated.

## 2 OBJECTIVE

Obtain the situational diagnosis of the area covered by the family health strategy based on the ERP

## 3 METHODOLOGY

The DBE was carried out in the Family Health Strategy (ESF), in Blumenau, SC, from August to September 2022, through the development of the following steps: 1st) collection of information through a questionnaire on the identification of diseases and health services, including access and the unit's work process, answered by users who attended the unit in the proposed period; 2nd) the questionnaire was applied in a team meeting with ESF professionals, medical students who do internship at the unit where everyone could report the problems experienced daily. 3) sociodemographic data taken from the electronic medical record of the municipality and the e-SUS database were used, being divided into micro-areas for better diagnostic evaluation of the territory. 4º) territorialization was carried out, field observation of the coverage area making it



possible to identify areas of social vulnerability, local geography and its risks, afforestation, distribution and accessibility to existing services, among others.

Finally, the data collected were systematized and distributed in tables, graphs and images presented at team meetings; based on these, through the identification of the weaknesses of each area of coverage, the implementation of the PES was elaborated, in order to outline actions for the reorganization of the work process.

#### **4 RESULTS AND DISCUSSION**

The structural problems faced and identified as a priority were the deficit in thermal and acoustic comfort, some outdated equipment, lack of a complete team, inadequate accessibility, among others that affect the team daily, such as work overload.

Community participation in the local health council in the search for health improvements and access to the territory is scarce. According to the municipality's health information system, the composition of the territory has 2801 registered users, 745 families, and has 05 micro-areas. However, the number of registered users does not match the reality observed in the work process.

The distribution of the population by age group in the territory points to a reality not found nationally according to IBGE, as it presents an inverse pyramid showing that a large part of our users are elderly and adults, a fact that implies planned actions for care with these users, such as actions aimed at chronic non-communicable diseases (NCDs), with the purpose of promoting the quality of life of this portion of users.

The geography of the area is predominated by hills, pointed out in the interviews as a limiting factor to access to the FHS, including by the elderly population that has mobility restrictions and consequently reduced coordination of care.

According to the interviews, the main problems in the community are the increase in the incidence of mental disorders in adolescents and the significant increase in users with NCDs and neoplasms in adults and the elderly.

It is essential to report the social vulnerabilities of the community, such as low income and consequent limitation in the acquisition of medicines not available by SUS and quality food, as well as the increase in unemployment. These are very serious points for public health, as they directly affect the basic needs of the user.

According to the information obtained, the most prevalent NCDs are Systemic Arterial Hypertension (SAH) and Diabetes Mellitus 1 and 2 (DM) in the community, with 428 users with SAH and 118 users with DM. Of these, 118 are at high cardiovascular risk, and according to the



VIGITEL - 2021 survey, the percentage of people with SAH has increased among women, as has that of DM. The estimated prevalence VIGITEL 2021 was 26.3% for SAH and 9.1% for DM. If we consider this percentage for the ESF territory, proportionally we would have 736 users in follow-up for SAH and 254 users in follow-up with DM, which led the health team to the following reflection: "Where are these users?", "Is there any limiting factor to access the service?".

In relation to the work process, some aggravating factors were pointed out, and of these, the way of welcoming users stands out, reinforcing the need for continuous training of the team.

Also, there was a lack of information on gender and sexual orientation issues for the lesbian, gay, bisexual, transsexual and transgender, queer, intersex, asexual and other (LGBTQIA+) population, which should be questioned during the registration carried out by community health agents (CHA). Knowing that the lack of data collection implies the estimation of this population in the face of public policies, it is necessary to overcome this flaw through permanent education with CHWs.

## **5 FINAL CONSIDERATIONS**

From the ERP, we had the recognition of the area of coverage of the territory, as well as we identified organizational problems, access of users and actions that can be enhanced in the area of action of the ESF.

The ERP enabled the presentation of the weaknesses of the FHS based on the needs pointed out and difficulties perceived in the work process by the community, guiding the planning of health education actions for users, such as workshops, and permanent education for the team. In addition, the ERP strengthened the link between the community and the ESF team, facilitating greater resolubility in PHC.



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