

Research in Progress

Needs, practices and social support: subjective dimensions of social determinants of health

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Abstract

The individual's role in view of the social and health inequalities does not occur passively; there are strategies, many times ignored by the social services, which cause the search for care. It is believed that the social groups set forth support relationships by configuring social networks which define therapeutic practices and cooperate in confrontation of daily situations. Thus the purpose of this research is to know and understand the needs in health, the therapeutic practices and the social support in the community of Rincão dos Maia, Canguçu, RS, having social inequalities as background. For that a quantitative-qualitative methodology was used by means of forms, semi-structured interview, participant observation and field journal. By considering that the health needs are heterogeneous, the practices performed to meet them correspond to different strategies such as deployment of resources by means of social support of adopted therapeutic practices. The approach of these dynamics will lead to the understanding of health needs, incorporating local realities aiming to contribute to the formulation of decentralized public policies accounting for the citizens' demands.

Keywords

social support; social inequality; rural population; public health; poverty

It is believed that individual's role in view of social and health inequalities does not occur passively; there are strategies, many times ignored by the social services which motivate the search for care, whether establishing a connection with the supporting networks in the community or in the mobility in search of therapeutic practices and services to meet the health needs. In this aspect we observe that the population has been developing such movements, many times unnoticed but which,

however, comprise experiences built up from their logic of action, which can be identified in the movement and in the subjects' health practices. Thus, it is necessary to know the "ways to do" of this collective by identifying the practices directly and indirectly related to their experiences in health and sickness and which may point out to a way for the incorporation of other perspectives in the logic of health services from the concepts and needs identified by the users (Acioli 2006).

This study aims to explore a life context to understand the health needs and practices used in the confrontation thereof, in a rural community having the social and health inequalities as background expressed in material and immaterial dimensions of the social life, considering the different individual capacities and social networks. Such proposal envisages an in-depth observation of the relationship between the health needs identified by the families, the practices and social networks of formal and informal support. Therefore the purpose of this research is to know and understand the needs in health, the therapeutic practices and the social support in the community of Rincão dos Maia, Canguçu, RS, having the social inequalities as backdrop.

Social and health inequalities represent a large contribution to the disparities between the different social groups and may be understood as the persons' deprivation in developing their life and health capacities (CSDH 2005). For Graham (2004) the inequalities in health refer to the systematic disparities in health in groups and communities occupying different positions in the society, being observed in the mortality rates among socioeconomic groups translated into the risk of premature death of individuals. For the authors, the social factors influence health as well as the housing standard, the environmental influence and behaviors related to health.

The world scenario of inequalities in income distribution, life and health conditions as well as in the access to health services inspired the World Health Organization (WHO) at the World Health Meeting in 2004, through its Director General, Lee Jong-wook, to propose the creation of a commission to recommend public and inter-sector health policies aiming at interventions to improve life conditions and reduce inequalities between people. For that, the Commission of Social Determinants in Health (CSDH) was created in 2005 (CSDH 2005), for which such determinants are the social conditions in which the persons live and work. They also point out to the specific characteristics of the social context which may affect health as well as the way in which the social conditions translate such impact.

In Brazil, the National Commission of Social Determinants of Health (CNDSS) was created by means of a Presidential Decree on March 13, 2006, integrated by sixteen prominent personalities of social, cultural, scientific and business life also having a Inter-sector Work Group represented by 16 ministries of economic and social areas. The Commission's main purposes are to produce knowledge on the DSSs, support the development of public policies and civil society mobilization for awareness and acting on DSSs (Buss & Pellegrini Filho 2007).

It is believed that the union of efforts among researchers, managers and the civil society is an important step towards a deeper knowledge of inequalities experienced by people and point out to alternatives so that they can be reduced or remedied taking into account other variables, in addition to the socioeconomic ones.

In this aspect, the importance of incorporating the subjective dimensions to qualify the social inequalities lies in the understanding that the social support cooperates in the confrontation of these disparities (Nguyen et al. 2003). The authors consider that the social support is locally and historically produced by appearing as an important factor in the confrontation of disease situations which are not restricted only to the biological and material field. For that, such dimensions need to be considered in a wide geopolitical analysis of the Health System.

The exchanges set forth in the social network go from material assistance and provision of services to counseling and company in leisure activities. Social networks enable the access to resources not provided by the State or the market, using a principle of gift and reciprocity (Portugal 2006). The authors would emphasize the way in which the access to resources of several natures is processed, which are closely related to the shape of networks – networks formed by strong ties or weak ties, by kinship ties, restricted or widened – implying different results in the access to resources, satisfaction of needs and confrontation of difficulties or risk situations. The reflections and analysis in relation to social support will be subsequently deepened.

As to the health needs we should take into account the plurality of spaces where the persons live as well as consider the diversity of individuals' choices. According to Stotz (1991) health needs appear as social categories and are historically built. By considering the health needs and their historical construction we resort to the concept of health formulated by WHO in 1948, which appears somewhat utopian but which is still used, and expresses that "health is the state of most complete physical, mental, social and spiritual well-being and not only the absence of illness". Thus it is believed, as Dejours (1986) that the most complete well-being, whether it is physical, mental, social or spiritual, does not exist. The author relates health to hope as something originating from the interior of each being, and not an exclusive matter of an institution or professional category. In this aspect, "health is something we conquer, we face and defend" (Dejours 1986:6).

By contributing to a expanded concept of health, Melo (2005) complements that it may be understood as a social right, going well beyond the specific actions of promotion, prevention, rehabilitation and recuperation thereof, as its determination involves life, work, environmental, and emotional conditions as well as other conditions required to the continuation of life with a minimum of quality.

The analysis of therapeutic practices or itineraries allows for the understanding of the confrontation of health and disease issues which are shaped from the context where the people live as well as from economic, social and cultural aspects which organize the collective life and biological life, resulting from a space of social action and interaction (Gerhardt 2000).

In this aspect, the authors report that the choice for a certain therapeutic practice is influenced by several

factors, such as age, sex, social class, occupation, race, family and social interaction as well as characteristics of the health problem faced and perceptions thereof; the fact that it is a chronic, acute, serious or benign situation; the understanding of what disease means and the availability of services translated into the access, the connection and quality. All these factors will influence the therapeutic choice by resulting in a pluralism in the search for the care and assistance which in turn will result in the choice for a shaman, a cleric, a health professional, self-medication or even no treatment at all (Gerhardt 2000).

Thus it is believed that the social groups establish supporting relationships, configuring social networks which define therapeutic practices and cooperate in the confrontation of daily situations. The health team may participate in such network to the extent that, being inserted within a community it shares its daily life and represents a support in situations of illness. However to expand such performance it is necessary to develop collective support ties and share the users' needs.

This research is a Master's Degree Thesis Project of the Graduate Studies Program in Nursing of the Nursing School of Rio Grande do Sul Federal University. The proposal integrates a Project called "Social Determinants and Interfaces with Users' Mobility: Analysis of Flows and Utilization of Health Services", developed by a team of researchers of the Collective Health Research Group (GESC) of this School and the Interdisciplinary Group of Research in Environment and Development (GRIMAD) of the Graduate Studies Program in Rural Development of same University financed by Edict 026/2006 MCT/CNPq/MS-SCTIE-DECIT.

The study is being developed through a quantitative and qualitative approach with hybrid methodological perspective. Referring to such combination, Minayo and Minayo-Gómez (2003), report that these are two differentiated forms of communication and both should converge to the same goal by approaching the nearest possible of the reality they propose to discuss. Briceño-León (2003) offers four models for the development of quantitative-qualitative nature studies. This study fits within the second model which the author calls "quantitative investigation to the beginning" (Briceño-León 2003: 171). According to the author, this model allows us to statistically analyze the data to progress in the knowledge and develop hypotheses. The qualitative investigation, in turn, allows us to interpret the quantitative data when they cease being numbers only and start being players. The qualitative dimension is of great use to assign a meaning to statistical data (Briceño-León 2003).

The data collection occurred in two stages: in the first all families were visited in a total of 241; the variables explored at this stage were socio-demographic, referred morbidity and life conditions. In the second semi-structured interviews were made with questions referring to the concepts of health and illness, therapeutic practices and social support. The sampling was random

and its size defined by the data saturation which was obtained with 18 interviewees. Then the participation of a lower number of families was observed in relation to their therapeutic practices and social support.

As to the analysis a typology of three social layers was made from the information of life conditions. Individual information is occurring by unvaried and bivaried frequency analyses. The Pearson chi-square test was used to perform the bivaried analysis. The qualitative data analysis followed the thematic categorization. The genogram and relationships diagram were used in the social support networks, which allow the description of the network structure, connections and forms of exchange within a group of persons. The project was approved by the Research Ethics Committee of Rio Grande do Sul Federal University, Meeting Number 2, Minutes Number 82 of 1/3/2007A.

The region selected for the development of the GRIMAD research is known as the "South Half" of the State of Rio Grande do Sul which has been going through an increasing economic deceleration as compared to other regions of the State, which makes clear the regional disparity. However due to the size of the area it was necessary to reduce it to eight municipalities: Arambaré, Camaquã, Canguçu, Chuvisca, Cristal, Encruzilhada do Sul, Santana da Boa Vista and São Lourenço do Sul. These towns were selected according to different elements: study area under stagnation and decline from an economic standpoint, presenting factors which indicate the existence of strong environmental impacts due to rice and tobacco planting activities and mineral extraction; from a social standpoint its justification is given by the existence of a diversity of social groups and productive systems; presence of *quilombo* remains and more recently of several rural settlements (UFRGS 2005). The study of these elements and relationship of demographic, social and economic data of the study region have suggested the existence of two major spaces which agglutinate situations of dynamism and stagnation, respectively represented by Camaquã and Canguçu (UFRGS 2005).

On considering Canguçu as stagnant pole we think in which social dynamics pervade the impoverishing and enriching situations in the town, and such dynamics are formed by different elements which influence on the social determinants by acting on health. In view of material conditions of inequality, the population reacts or not by means of strategies which may contribute to the confrontation, overcoming or conformity thereof. The choice of this town for the development of the study occurred so that we can understand the transversality of life situations in the health field. Therefore the context of experienced social and health inequalities will influence the needs and the way how they will be perceived by the people as well as the adopted therapeutic practices are oriented to answer to such needs. This way, the social support comprises a strategy in the confrontation of daily situations which appear; hence this study may reveal quite a great deal in the way of life of this community.

The municipality of Canguçu has a total population of 51.427 residents out of which 17.685 (34.4% of the population) live in the urban zone and 33.742 (65.6% of the population) live in rural areas, and it is divided into five districts and 120 localities. The locality of Rincão dos Maia (Figure) is located in the 1st District

with a population of 814 people and 241 families. The typology of life conditions identified three layers: lower with 100 families, middle with 103 and upper with 38 families. The defining variables were in relation to housing conditions, presence of bathrooms and destination of effluents.



Canguçu municipality, RS – Brazil and Rincão dos Maia community. Source: Fialho, 2005.

The stage of social-demographic characterization of the families was an important moment for the first approach when it was possible to feel the suspicion and concern with the research purpose. However these feelings were replaced with passing of time by narratives of life stories, wishes, pains and hopes. The concept of health for these people is very close to strength and energy for work as well as illness is related to excess of sun exposure, rain and winds during labor. The therapeutic practices are related to the search of health care and assistance which would attenuate the physical or psychic suffering. The social support received by the families is sporadic caused by some request for help.

Considering that the health needs are heterogeneous and that the attempted practices aim to meet them by means of geographic mobility or through such resources as social support, we see in the approach and understanding of these dynamics an opportunity to contribute to the development of public policies which will generate actions to incorporate the local realities. McCarthy (2002) corroborates with this idea by encouraging

the investment in Public Health at local level, so that health professionals will know further and work closer with the people from one location and region as well as in the exercise of inter-sector actions.

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