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ORIGINAL ARTICLE

SOCIAL DETERMINANTS OF HEALTH THAT INFLUENCE THE HEALTHY LIVING PROCESS IN A VULNERABLE COMMUNITY

DETERMINANTES SOCIAIS DE SAÚDE QUE INFLUENCIAM O PROCESSO DE VIVER SAUDÁVEL EM UMA COMUNIDADE VULNERÁVEL

DETERMINANTES SOCIALES DE SALUD QUE INFLUYEN EN EL PROCESO DE VIDA SALUDABLE EN UNA COMUNIDAD VULNERABLE

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ABSTRACT

Objective: knowing the social determinants of health that influence the healthy living process in a vulnerable community. **Method:** grounded theory, where data were collected through the individual interview technique with a theoretical sample of 38 interviews, among users, health professionals, and community leaders, and analyzed in a systematic and comparative manner. **Results:** vulnerabilities caused by social health macrodeterminants are apparent, and the position of families and communities within the hierarchies of power, labor, employment, access to health services, and income levels will determine the various healthy living opportunities for the individuals. **Conclusion:** the social determinants of health that influence the healthy living process are related to socioeconomic, cultural, and environmental vulnerabilities and poor basic human needs. **Descriptors:** Social Determinants of Health; Health Inequalities; Equity; Nursing; Community Health Nursing.

RESUMO

Objetivo: conhecer os determinantes sociais de saúde que influenciam o processo de viver saudável em uma comunidade vulnerável. **Método:** teoria fundamentada nos dados, no qual os dados foram coletados por meio da técnica de entrevista individual com amostra teórica de 38 entrevistas, entre usuários, profissionais da saúde e lideranças comunitárias, e analisados de forma sistemática e comparativa. **Resultados:** as vulnerabilidades ocasionadas pelos macrodeterminantes sociais de saúde são evidentes, sendo que a posição que as famílias e comunidades ocupam dentro das hierarquias de poder, trabalho, emprego, acesso aos serviços de saúde e níveis de renda irá configurar as diferentes oportunidades de viver saudável dos indivíduos. **Conclusão:** os determinantes sociais de saúde que influenciam o processo de viver saudável estão relacionados às vulnerabilidades socioeconômicas, culturais e ambientais e as necessidades humanas básicas insatisfatórias. **Descritores:** Determinantes Sociais da Saúde; Desigualdades em Saúde; Equidade; Enfermagem; Enfermagem em Saúde Comunitária.

RESUMEN

Objetivo: conocer los determinantes sociales de salud que influyen en el proceso de vida saludable en una comunidad vulnerable. **Método:** teoría fundamentada, donde se recogieron datos a través de la técnica de entrevista individual con una muestra teórica de 38 entrevistas, entre usuarios, profesionales de la salud y líderes comunitarios, y analizados de manera sistemática y comparativa. **Resultados:** las vulnerabilidades causadas por macrodeterminantes sociales de salud son evidentes, y la posición que las familias y las comunidades ocupan dentro de las jerarquías de poder, trabajo, empleo, acceso a servicios de salud y niveles de ingresos determinarán las diversas oportunidades de vida saludable para los individuos. **Conclusión:** los determinantes sociales de salud que influyen en el proceso de vida saludable están relacionados con las vulnerabilidades socioeconómicas, culturales y ambientales y las necesidades humanas básicas insatisfactorias. **Descriptor:** Determinantes Sociales de la Salud; Desigualdades en Salud; Equidad; Enfermería; Enfermería en Salud Comunitaria.

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INTRODUCTION

There is a tendency to promote health policies addressing the social determinants of health (SDHs) because they interfere with well-being, functional independence, quality of life.¹ They are defined as the social characteristics within which life unfolds², or as the social conditions under which people live and work.³

In 2005, the Commission on Social Determinants of Health of the World Health Organization (WHO) was created and, in 2006, in Brazil, the National Commission on Social Determinants of Health (CNDSS) emerged, in order to recognize health as a public good, strengthen the Brazilian Sanitary Reform process and encourage discussion activities on the social situation, by developing strategies to eradicate social inequities and poverty.^{3,4}

In Brazil, this definition was expanded, where the SDHs are, therefore, social, economic, cultural, ethnic/racial, psychological, and behavioral factors that influence the occurrence of health problems and their risk factors among the population.⁵ Considering them, from this perspective, the importance of social and community networks is reinforced, characterized by relatives, neighbors, religious groups, neighborhood associations, which establish the relations of solidarity and trust that constitute the social capital.⁶

Healthy living emerges as a social phenomenon, which generates inequality in terms of exposure and vulnerability, understood as a circular interactive and associative process, streamlined by experiences of order and disorder in search of a continued individual, family, and social experience.^{7,8} This goes beyond the linearity of the health-disease phenomenon, traditionally described through the concept of cause and effect, disregarding the social, emotional, economic, and spiritual dimensions of a human being.⁸⁻¹⁰ To do this, there is a need to provide contextualized responses on the various ways involving healthy life as a multifactor process.

We notice the need to know and grasp healthy living in vulnerable communities due to the socioeconomic, cultural, and environmental problems people face. Vulnerable communities experience environmental, economic, political, and cultural influences, which make relationships weaker, as well as interactions and individual, family, and social associations¹¹⁻², triggering the need to discuss the social determinants of

health. Vulnerable communities, in the Brazilian context, constitute a majority of those participating in the Family Health Strategy (FHS), which is a project that streamlines the Brazilian National Health System (SUS), regarded as a strategy for reorganizing the health care model, operationalized by creating multi-professional teams in primary health centers.¹³

When considering the importance of nurse's work in this context of discussions, which involves a new epistemological view of the healthy living dynamics, we ask: which SDHs influence the healthy living process?

OBJECTIVE

- Knowing the social determinants of health that influence the healthy living process in a vulnerable community.

METHOD

The qualitative research process was based on grounded theory, which is intended to identify, develop, and relate concepts based on data collected, analyzed, and compared systematically and concomitantly. The development of a theoretical framework denotes a set of categories, constructed through emerging themes and concepts that indicate relationships, capable of constituting an explanatory theoretical framework of a social phenomenon.^{14,15}

Data were collected through the individual interview technique, between March and June 2011. In total, the theoretical sample consisted of 38 interviews, namely: users (n = 24), professionals from a FHS team (n = 12), and community leaders (n = 2), all members of a community, with around 26,000 inhabitants, which is characterized as vulnerable, both socially and economically, as well as from a political, environmental, and health-based viewpoint.

In accordance with the theoretical sampling process, the first group of participants, chosen by the researchers, consisted of 24 users enrolled in the FHS team, selected by drawing of records, in the local primary health center. The interviews were conducted by means of the following questions: What does healthy living mean to you? and Which are the factors that influence your healthy living dynamics? The interviews were recorded and transcribed, then data were organized and analyzed in order to identify the empirical data defined as codes, based on the comparative analysis technique.

The analysis of data collected in the first sampling group allowed the creation of initial

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properties and assumptions that guided the creation of the second group, consisting of 12 professionals from a FHS team, who knew the users drawn in the first group. Among the respondents in the second group, there are: nurses, physicians, nursing technicians, and community health workers. The questions asked in the interviews were: What do you see as healthy living? and Which are the factors that determine healthy living among users at your working area?

Data from the second group served to deepen the structure of the theoretical model, reinforcing the categories created by analyzing data from the first group, as well as secondary data, and they provided additional information pointing out specific elements of the influences of social determinants of health within the healthy living process.

As a result, it was decided to create a third group of participants, consisting of two community leaders, who were selected due to their renowned local community engagement. They have been interviewed through the following questions: What does healthy living mean to you? and Which are the factors that determine healthy living in your community? All interviews were recorded and transcribed by the researchers.

Data collection and analysis was carried out in a systematic and comparative manner. For each interview, data were transcribed and there was a thorough review of the text. Then, the identification of conceptual units began. Data were coded line by line, compared to each other, and classified into categories. In the next step, the researchers chose an open coding category - first codification stage - and defined it as the central theme, compared to the other categories. In the next phase, also named as axial coding, data were grouped into new forms, seeking to expand and compress the central category based on theoretical connections.¹⁵ To ensure the anonymity of subjects, users are identified by means of the letter “U,” health professionals through “P,” and community leaders through “L,” and numbered according to the order of interviews.

All participants, after being informed about the method and the research objectives, signed the free and informed consent term, in compliance with the resolution issued by the Brazilian Ministry of Health¹⁶, and their free access to collected data was guaranteed. Participants were also informed that their names would not be disclosed and that they could withdraw from the study at any time, without restrictions. The study was approved

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by the Research Ethics Committee of the Centro Universitário Franciscano (UNIFRA), under the Protocol 333/2008.

RESULTS

The data analyzed in a systematic and comparative manner resulted in four categories, namely: Socioeconomic, cultural, and environmental vulnerability; Poor basic human needs; Interventions that make healthy living easier or more difficult; and Interactive and associative strategies that enhance healthy living.

According to respondents, healthy living represents an ongoing process, which makes it possible to emancipate subjects in a vulnerable community. They realize the need for individual and community awareness, capable of enabling the perception of healthy living as something unique, interactive, associative, circular, complex, political, and social, constituted by active and participatory engagement of users. They brought to discussion the need for effective involvement of users in the healthy living dynamics, in order to enable social emancipation by means of the leading roles as authors of their own history.

◆ Socioeconomic, cultural, and environmental vulnerability

Socioeconomic vulnerability can be seen through the employment and working conditions within the community, where most individuals do not have a steady job or a formal job, thus their labor rights are not guaranteed due to informal employment or self-employment. We can notice in the account a feeling of social exclusion regarding the center and the periphery, where the socioeconomic status directly affects the healthy living of these individuals.

Regarding the cultural and environmental vulnerability, respondents mention the lack of leisure and promotion of community culture, considering that there are spaces available to do this, but they are not used by local administrators. It is noticed that culture is limited to specific actions, this is not a process involving the various kinds of individuals, families, and communities. The environment is still perceived by people in a linear way, as the backyard of their households, but not as the comprehensive setting around them, and this generates influences on them and the community they live in.

◆ Poor basic human needs

Weak healthy living, according to respondents, is associated with poor basic

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human needs. This perception is linked to working conditions, safety, food, housing, interpersonal relationships, life expectancy, study opportunities, financial conditions, access to health services, among others: *“Look, I think that healthy living for us here means our basic sanitation”* (U10).

Regarding health accessibility, users are focused on the need for medical care and distribution of medicines in the primary health center, in order to be good-quality and problem-solving resources. In this regard, healthy living is associated with a biomedical and assistance-based view in health care, as denoted by the following accounts: *“I think that healthy living means resorting to medical follow-up and not having to go from one place to another to tackle health problems”* (U7).

Most health professionals and community leaders already rely on a comprehensive view. They reflect the need for contextualized perceptions in reality and an expanded health concept, as well as awareness of the unique way how each individual and family communicate. *“There is no use for us in coming here to get medicines, receiving advise, and going home. There is a need to contextualize such a reality and realize that healthy living goes far beyond”* (P7).

♦ Interventions that make healthy living easier or more difficult

It is noticed that there are factors that positively and negatively influence the healthy living of users and families in the community concerned. Interventions that emerge as making the healthy living process easier are interaction and intermediation of undergraduate students in health sciences, which enable new questions and insights into the health-disease process. The role played by the community health worker (CHW) stands out as a reference for families, providing mediation between the FHS team and the community.

The socialization groups held in the community, e.g. women's group, with discussion of everyday life themes, strengthen interactions and family and community associations, contributing to avoid social isolation: *“Before, I was always depressed. After I joined the group, I started talking more, then I improved a lot... I saw it was bad to be locked up at home. Now, I am another person. I feel more energized about living and working”* (U1).

Negative interventions of healthy living are associated with weak family and community

interactions, reflected by poor popular participation, accommodation, alienation, depression, high rates of teenage pregnancy, drug trafficking, and prostitution. Still, in this regard, respondents mention that the ready-made speech of health professionals, in some cases, reproduce a traditional hegemonic model, and this makes healthy living more difficult, resorting to talks that are meaningless for users. The influence of party politics is a factor that weakens community relations, as well as prevents the achievement of meaningful new spaces for sharing experiences and making questions also focused on social and political connections.

♦ Interactive and associative strategies that enhance healthy living

As strategies that enhance healthy living, respondents mention academic mobility as a stimulus for user autonomy, strengthening the perception of the whole and need for community solidarity. One of the community leaders concerned also refers to community participation and engagement, in order to strengthen public and social control policies, reinforcing the need for user involvement in political and social struggles, through social control.

The CHW plays a key role in interactive and associative strategies, due to his/her knowledge of needs and struggles in the community under study and because he/she lives in that location. However, the results showed the need for greater professional training and qualification of the CHWs, so that they can go beyond a vulnerable reality and be effective in playing their role as mediators between health services and the community, through user's empowerment. The need for an academic background and a focused continuing education for the FHS is highlighted, too, where the professional feels like a player regarding the community realities since the undergraduate course and can act through systemic actions to enhance the healthy living process among users.

The data analysis process has led to the preparation of a theoretical reference model, which demonstrates the interactivity and circularity of factors that determine the healthy living process within a vulnerable community, as illustrated by Figure 1.

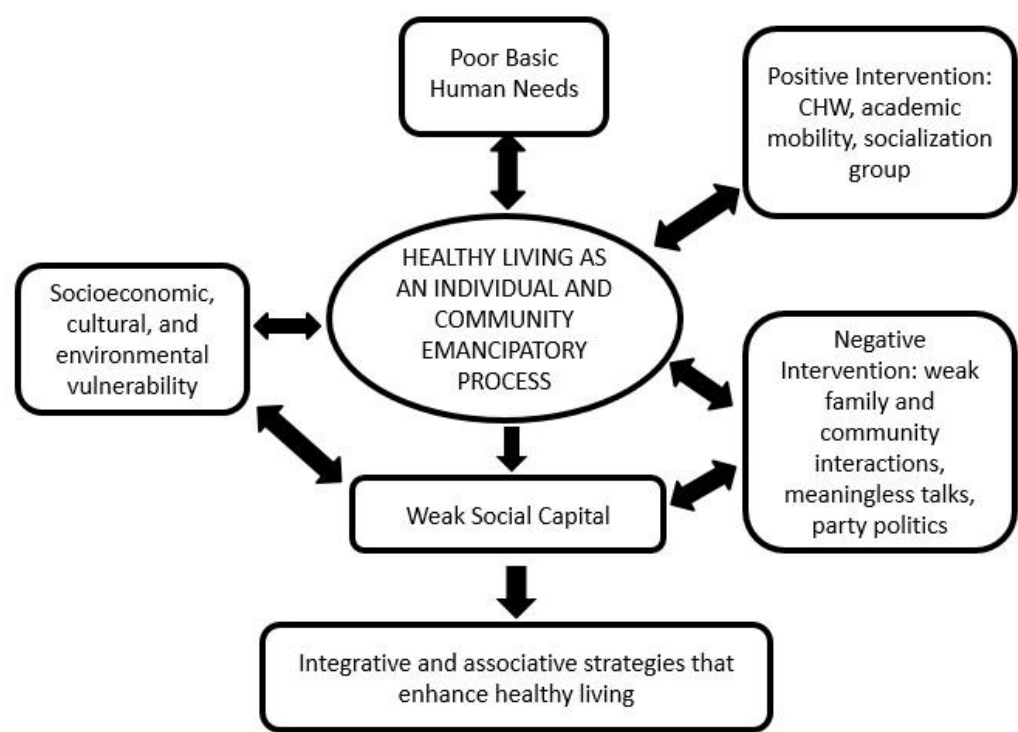


Figure 1. Theoretical reference model on healthy living in a vulnerable community.

DISCUSSION

Healthy living emerges as a unique, complex, dynamic, and circular process, which interacts with the individual, family, and community dimensions, coupled with internal and external factors, such as: well-being, access to public health services, leisure, education, party politics, basic sanitation, among others. So, healthy living is unique for each user and it is directly and indirectly influenced by SDHs, depending on the significance of a SDH to the individual. This is a complex process, because it involves both relational and interactive determinants and associative determinants. While, for some, healthy living means enjoying perfect health, for others it means living without any disease, and for others it also means keeping a harmonious balance between the contradictions of life.^{10,17}

In line with the idea of healthy living exposed above, the conceptual model proposed by Dahlgren and Whitehead shows the SDHs in their various dimensions, going through lifestyle, social and community networks, living and working conditions, and the macrodeterminants, which include general socioeconomic, cultural, and environmental conditions.¹⁸ The SDHs are related to healthy living, but healthy living denotes a greater subjectivity nature, where a dialogue to the SDHs is allowed and each one has a value depending on the individual.

The vulnerabilities caused by social health macrodeterminants are apparent, and the position that families and communities occupy within the hierarchies of power, labor,

employment, access to health services, and income levels will set the various individuals' opportunities for healthy living.^{1,19} This advance in perception is marked in the study of health inequalities, i.e. those health inequalities between communities that are systematic and relevant, and they are also avoidable, unfair, and unnecessary, involving poverty and health, socioeconomic stratification, and mechanisms to produce inequities, affecting the individuals' healthy living process; such inequalities should be reduced.²⁰⁻²²

The analysis of relations between the individuals' healthy living, inequalities in living conditions, and the degree of development of ties and associations within the communities proves to be necessary. The impoverishment and weakening of social capital generate fragile bonds of community cohesion, caused by social inequalities due to low investment in human capital and social support networks, key for healthy living.^{6,22-3} It takes greater equality and high social cohesion so that we can achieve a strengthened and engaged social capital in community and global actions.

Impoverished social capital refers to a reductionist view of healthy living, which is associated with meeting basic human needs. When there is a lack of basic needs for a dignified life, resorting to a wide view with regard to the concept of healthy living and SDHs themselves shows up as an emerging difficulty, because the individual needs some understanding about her/himself, the community, and everything around

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her/himself to be able to go beyond the barriers of her/his reality.²⁴⁻⁵

Therefore, access to health services is a part of the SDHs and it emerges as an individuals' basic human need. The health system is a powerful intermediate determinant in the chain of social production in health, especially due to universal access, which allows to address directly differences in exposure and vulnerabilities, preventing individuals, especially in vulnerable situations, to be pushed into poverty because of high costs of health care.^{1,26}

Within the context of health services, the CHW is regarded as the professional who is closest to families and the community, where she/he should refer people to the FHS, provide health prevention and promotion, guides users' treatment and rehabilitation, engage with the community in search of environments and conditions favorable to life.¹³ However, it is clear that her/his practical actions are often based on specific actions, such as the delivery of medicines and scheduling of appointments.^{13,27} There is a need for strategies capable of turning the CHW into a proactive professional, able to grasp the context of issues where she/he operates.

The nurse, like other professionals from related fields, needs to gradually expand her/his thinking/doing/experiencing within SUS, which require a proactive and participatory professional action, aimed at emancipating users.^{13,28}

Thus, knowing the SDHs that influence healthy living in a vulnerable community opens access to the choice of political and social interventions needed to reduce inequities in health.^{1,24}

CONCLUSION

The social determinants that influence the healthy living process in a vulnerable community are related to socioeconomic, cultural, and environmental vulnerabilities, poor basic human needs, interventions that make things easier or more difficult, which require interactive and associative strategies to enhance healthy living.

The study results show, in short, a reductionist and linear view by some professionals in relation to the healthy living process. While the users of health services mention their basic needs, such as food, housing, employment, access to health services, among others, health professionals and community leaders point out, even in an incipient manner, healthy living as a relational

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and associative process, which involves a circular motion between individual, family, and community.

Healthy living as an individual and community empowerment process requires interactive and associative strategies able to strengthen community solidarity and enhance social capital. Thus, health is a reflection of proactive attitudes that consider the social macrodeterminants and stimulate the individual as a social actor and protagonist of her/his own history.

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