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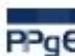

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RESEARCH

Community participation in basic health care in the user's perspective

Participação comunitária no contexto da atenção básica em saúde na perspectiva de usuários

Participación comunitaria en el contexto de la atención básica en salud en la perspectiva de usuarios

Jael Maria de Aquino [1] , Estela Maria Leite Meirelles Monteiro [2] , Waldemar Brandão Neto [3] , Andreza Cristina Velez Silva [4] , Bruno Lima de Albuquerque [5] , Rebeca Barroso Batista [6]

ABSTRACT

Objective: To know from the perspective of the user, the contributions of community participation in health activities of a family health unit of Recife-PE, Brazil. **Method:** Qualitative study conducted with 65 users a basic health Unit in the months of November 2010 to January 2011. The interviews recorded, transcribed and analyzed by means of the collective subject discourse. **Results:** Two central ideas identified: - existing in the Community Leadership and participation of the population in the planning of health;-Suggestions for changes/improvements in health service offered by the basic unit. **Conclusion:** Evidenced that the question of community leadership needs to strengthen through a political action-ethics-shared citizen, where professionals and users are active in this process, recognizing themselves as allies within the complexity that involves health issues in the context of capitalism and private interests. **Descriptors:** Community involvement and family health, Access to health services, Social control policies, Community health nursing.

RESUMO

Objetivo: Conhecer, sob a ótica do usuário, as contribuições da participação da comunidade nas ações de saúde de uma Unidade de Saúde da Família da cidade do Recife-PE, Brasil. **Método:** Estudo qualitativo realizado com 65 usuários de uma Unidade Básica de Saúde nos meses de novembro de 2010 a janeiro de 2011. Os depoimentos foram gravados, transcritos e analisados mediante o Discurso do Sujeito Coletivo. **Resultados:** Foram identificadas duas ideias centrais: - Lideranças existentes na comunidade e participação da população no planejamento das ações de saúde; - Sugestões para mudanças/melhorias no serviço de saúde ofertado pela Unidade Básica. **Conclusão:** Evidencia-se que a questão da liderança comunitária necessita ser fortalecida por meio de uma ação política-ética-cidadã compartilhada, onde profissionais e usuários sejam ativos neste processo, reconhecendo-se como aliados dentro da complexidade que envolve as questões de saúde no contexto do capitalismo e dos interesses privados. **Descritores:** Participação comunitária, Saúde da família, Acesso aos serviços de saúde, Políticas de controle social, Enfermagem em saúde comunitária.

RESUMEN

Objetivo: para conocer, desde la perspectiva del usuario, las contribuciones de la participación comunitaria en las actividades de salud de una unidad de salud de la familia de Recife-PE, Brasil. **Método:** estudio cualitativo había realizado con 65 usuarios una unidad de salud básica en los meses de noviembre de 2010 a enero de 2011. Las entrevistas fueron grabadas, transcritas y analizadas mediante el discurso del sujeto colectivo. **Resultados:** se identificaron dos ideas centrales:-los líderes existentes en la comunidad y la participación de la población en la planificación de la salud; -Sugerencias de cambios/mejoras en el servicio de salud ofrecido por la unidad básica. **Conclusión:** se pone de manifiesto que la cuestión del liderazgo comunitario debe fortalecerse a través de un ciudadano político acción-ética-compartido, donde profesionales y usuarios están activos en este proceso, se reconoce como aliados dentro de la complejidad que implica problemas de salud en el contexto del capitalismo y los intereses privados. **Descriptores:** Participación comunitaria, Salud familiar, El acceso a los servicios de salud, Las políticas de control social, Enfermería de salud comunitaria.

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INTRODUCTION

The Community contribution is a movement that has been encouraged and valued as an important strategic path to face health problems, allowing greater political awareness and sharing of information and responsibilities, in search of better autonomy and quality of life of people with the exercise of social control.[1]

One of the great milestones in the history of Brazilian health was guaranteeing the participation of citizens in public health co-management, through deliberative spaces organization of discussions and debates as the national movement for healthcare reform. This ideology had by Marcos of reaffirmation and consolidation the 8th and 9th National conferences, respectively, in 1986 and 1992, and of the municipal councils of health (CMS), which have composition, and parity assignments handled by rule of law.[2]

Health, as citizens ' rights, services and actions must be provided in a decentralized manner and subject to social control. Thus, the proposal from the Sistema Único de Saúde (SUS) is like the best doctrine of construction of citizenship.[3] based on this understanding rescues the importance of citizenship as the construction of a social space of equal rights, implying a reciprocal relationship of rights and duties between citizens and the State, seeking the materialization of the subject's wishes, through socio-political discussions; where the participation of those involved in this space may mean redistribution of rights to all.[4]

Thus, the citizen participation characterized by the replacement of category community or people by society as central category. This concept based on universalization of social rights, in adopting a broadened concept of citizenship and a new understanding of the character of the State, referring to the definition of priorities in public policies based on a public debate.[5]

Completed its more than 20 years, the SUS, has been consolidating as a health policy success, because its principles and fundamentals of rescue in the subject cultural beliefs and social values based on a new vision of health. Within this perspective, the SUS has focused on reorganization of health care through investment in the family health strategy (FHS).

The ESF adopts a new form of work organization in health to produce by a multidisciplinary team, with a view to developing health practices integral and resolute. In addition, is notorious for its peculiar characteristics that favor the integration between community and family health teams, as well as professional relationship-user.[6]

Teamwork, family health units, promotes the involvement and participation of the community in building a common outreach project, whereas the population of reference work is addressed, assuming a process of democratization of the institutions.[1]

However, the search for such participation, still looks shy, because study of the basic attention points to the absence of the user as the protagonist of his own living and

production of your care, because the team still puts the population outside the scope of decisions about what concerns you.[7] Thus the participation and social control no longer represent democratic strategies able to promote the break with the tradition of centralization of the Brazilian State.[8]

Another highlight result of a recent study in the context of family health held in southern Brazil, which verified that the deployment of the PSF investigated, dissociated from a collective discussion with users and professionals directly involved, which compromises the interweaving of social and technical devices required in daily practice of health services. [9]

Thus, the achievement of this research is justified by the need for renewal of postures and attitudes in the praxis of health professionals within the context of the work on primary health care, recognizing the potential of another and community resources for significant changes in the reality of health in an ethical-political-democratic movement.

Study the elements, which pervade in the real exercise of community involvement within the perspective of the worker process on basic health network's offer to professionals who operate an arsenal of possibilities for the understanding of the complex phenomena that govern and interfere on social dynamics work in community health. Allowing tread a path where to hear the population with their wishes and needs, breaks a little rigidity with which health services organized today. From these reflections, proposed the following problem: how users of primary health care services understand the issue of popular participation in the action planning in health?

In the search for better understanding of the phenomenon, the study has drawn up the following goal: meet, from the perspective of the user, the contributions of community participation in health activities of a family health unit (USF) from the city of Recife, Brazil.

METHODOLOGY

The research is descriptive, exploratory in nature with qualitative analysis approach for working with the universe of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a deeper space relations, processes and phenomena that cannot be reduced to the operationalization of variables.[10]

The study was carried out in a USF of Northeast Health District III 3.2, located Northwest of the city of Recife-PE has a total of 29 neighborhoods, in an area characterized by rugged relief with the existence of geographic barriers such as hills, slopes and stairways. The USF has two teams of health professionals, who are responsible to meet a demand of approximately 70 individuals daily, ranging from newborns to the elderly. Right next to USF is located a school daycare and an Association of residents of the neighborhood. The community enjoys candy, clothing stores and housewares, small food markets, butchers, composing a micro social space that are interwoven with local needs. However, there are few social spaces for leisure and well-being.

Participants selected at random, organized with the support of community health Agents (ACS), the draw of 8 residences for each of the 8 micro areas existing in the respective health 2-team unit investigated. As one of the micro areas, one user searched the researchers with the intention of interviewed; the study totaled the participation of 65 users.

It is worth mentioning, that the draw based on the day of the visit at home, held by ACS for each micro area resident family, that day the presence of researchers on site. Upon arriving at the House of the families the researchers presented the same by ACS, and, upon acceptance of one of the family members present in the House to participate in the research, the interview held after SCW activity.

The inclusion criteria for users: age 18 years or more; of both sexes; have fixed abode in the community where it operates the USF, focus of this research, and still be the same user; as well as presenting physical and mental conditions; and agree to participate in the study.

The data collected in the months of November 2010 to January 2011, by means of a semi-structured interview script previously tested. The technique used with MP3 recording for the record of statements addressing the following issues: characterization of the Group participant (socioeconomic data and family situation) and questions relating to social participation and knowledge of the leaders of the community, as well as suggestions for improvements/changes in health services offered by the basic unit.

The Research Ethics Committee of the Integrated Health Center Amaury de Medeiros (CISAM) da Universidade de Pernambuco (UPE) with registration No. 096/10 and 6030.0.000.250-10 approved the research: CAAE. Participants were explained the objectives of the research, its risks and benefits, as well as was guaranteed the preservation of their identities. All participants expressed the desire to insert in the search through the signing of an informed consent.

The empirical material analyzed by means of the method of the collective subject discourse (DSC), which is a mode of presentation of results of qualitative research, whose statements are his raw materials. The DSC built in first person singular, so the thought of a group placed as if it were an individual speech. This is an explicit suggestion of reconstitution of a being, or even of an entity, which exposes their collective empirical opinion in form of a subject of discourse delivered as if it were a single guy who speaks.[11]

Thus, when using this technique, selected from each individual response the most significant stretches of these responses, which are the key Expressions. These expressions match Central Ideas that are synthesis of discursive content expressed in the key Expressions. Therefore, from these Central Ideas the speeches-summaries are built.[12]

RESULTS AND DISCUSSION

Characterization of the participants

Of 65 users included in the search, there was a predominance of 89% (58) female and 11% (7) introducing male age group of 18 to 80 years. Such a situation been found in other studies, notably due to the social role historically assumed by women as caretaker of the family, being more easily found at home.[13]

In relation to the work situation, 37% (25) of the respondents work, and the other 63% (41) do not work. The most cited occupation types were as follows, 8% (2), 16% (4) are domestic, 12% (3) traders, 8% (2) seamstresses and 56% (14) have other occupations requiring little study and low pay.

How much schooling users had different levels of schooling, having 1% (1) not literate, 11% (7) literate, 43% (28) with incomplete elementary, 8% (5) with complete elementary school, 11% (7) with incomplete high school, 25% (16) with complete secondary education and 1% (1) with complete higher education.

In relation to marital status, 60% (39) are with partners, and 40% (26) without partners. In this respect, as it is still common to figure of the woman maintains the home. When considering the amount of children, found that 14% (9) do not have children, 60% (39) have three children 1, 12% (8) have four children and six of the 14% (9) are above six children.

As for the number of people who live in the residence, it identified that 5% (3) live with one person, 72% (47) live with 2 to 4 people, 20% (13) live with 5 to 7 people, and 3% (2) live with more than seven people. Related to this point it has been observed that individuals reside with a large number of people, but their homes have limited rooms, and 3% (2) who live in the House with 2 rooms, and 97% (63) who live at home with 3 or more rooms.

With the DSC's through the interviews obtained two central ideas (IC):-Existing in the Community Leadership and participation of the population in the planning of health;-Suggestions for changes/improvements in health service offered by the basic unit.

Central Idea I- Existing in the Community Leadership and participation of the population in health planning

Theme: Identify the leaders and shy community participation

The collective subject discourse: *I know, it's good people [...] is the community leader [...] now he's Alderman [...] he was Deputy [...] that post right here, he was the one who fought [...] he makes meeting the post, makes the doctors ' meeting, meeting about bus [...] help on lack of water [...] had a meeting there at the station several times, but to no avail [...] the people are very comfortable.*

Theme B: Not identify the leaders and present resistance as the Community contribution

The collective subject discourse**:** *I don't [...] If you have, I'm on the outside [...] has a business community there to elect "guy" or "Harry", but I've never been interested in it, because they don't do anything [...] I don't get involved very [...] we have no participation of anything and neither in the planning of health actions.*

Evidenced in the speeches above that the population requires a leader who can serve as a mediator of the community, always seeking the interests of the population, fighting mainly by the same participation in solving health problems in the community. Community participation along with the health team in building the action planning of health-focused assistance favors the real needs of the population.

Many health programs have carried out to the population, when the best would executed with the population on preparation proposals able to promote health and well-being to the conquest of citizenship.[5] thus; it becomes a challenge for professional health staff to mobilize the community, believing in its potential and power to change a reality. From overcoming the incipient idea that the community accommodated and does not accept, change. We must create opportunities for discussions and joint discussion arenas in decision-making with a view to resolving the existing health problems.

Identifies a complaint speech of indignation, but not one of collective participation in detection, prioritization and resolution of everyday problems and the Organization of health services. Notice, on the other hand, within the health services, the obstacle to popular participation (even with all the legal apparatus). That is because open the door and the interior health services means and implies sharing knowledge and powers.[2]

It is necessary to the understanding of the users as autonomous subjects, protagonists of their life stories and, therefore, active participants in the identification and prioritization of community issues and proposals for resolution.

In relation to speeches by users who do not identify the leaders, it was realized that these need to integrate with other members of the community, sharing ideas, dreams and goals that will meet the community's policy, not to run the risk of falling into the centralization of tackling the problems, decisions and strategies. You need to take the lead with sensitivity, responsibility and above all representative of a class who craves transformations, which can often disturb those who defend hegemonic proposals to live and act in society.

So, assume a posture of leader, other than the Chief or that charge, requires a work value, communicative, identifying limits and possibilities of managerial resources and tools. It should be recognized the exercise of leadership as a key factor to address the difficulties of implementing change processes in public health organizations, including aspects concerning the Organization of assistance, his humanization and the search for greater levels of institutional responsibility for its results.[14]

The fact some people not wanting to get involved with the choice of a leader who give voice and decision-making power to the people, identified in the speeches, reveals that these central figures of community representation need to give visibility to their actions on the population, showing interest in achievements and ideals built politically with all and that may contribute to significant transformations in health reality. Have a political stance

in the exercise of leadership is necessarily have an ethical, imbued with respect, humanity, solidarity, in the face of great corruption that takes care of our country, leading to an immense disbelief on the part of the population that the political practice is only for the rise of power and riches.

Central Idea II- Suggestions for changes/improvements in health service offered by the basic unit

With regard to suggestions for improvements and changes in the health service of the basic unit, evidenced in the speeches of the users numerous problems, especially the issue of humanization of health professionals:

Theme: Humanization of professionals

The collective subject discourse: *A better service because you have a health problem, you go in there already apprehensive, then if you find a person who gives you the hand, gives you a friendly Word, I think that's everything, you get confidence [...] is sometimes silly, a little trouble, but by the fact that you're treated badly. This causes a different reaction, because the doctor has to be a friend of the patient, because one needs the other, patient needs the doctor and the doctor needs the patient [...] improve doctors ' visits the houses [...] educate the staff at [...] was good change most employees because they don't have education [...] I wanted to change all the health workers there, which come from outside health agents working here, because it would give more value [...] coming from outside, the responsibility is another [...] the management is terrible [...] monitoring of timetables also [...] that a good Director, to make the people work right, treat people well.*

How could be observed in testimony to lack of humanization is pointed to as a barrier for those seeking the health service in order to receive a resolution to their State of health or even health care guidelines, in addition to establishing a distancing between the professional and the subject. Thereby, the paths that connect the human care promotion in its fullness, cease to be pursued jointly, as the professional, users/family/community that should be recognized as allies in health work, no longer act co-responsavelmente for the production of health.

In this context, it is vital to appreciate by the affection between team-community, feeding dreams, inspiring the future, and together they seek the resolution of problems and health needs, building a culture of solidarity, based on the common good and collective love.[15]

For a completion of the humanization of assistance, it is essential that there is adequate availability of professional, which demands a certain bodily and mental condition. It is important, in particular, both those responsible for the management of existing services on the institutions, as the own professionals be correspondents for the pursuit and adoption of measures favoring the promotion of emotional and physical wellbeing of themselves and the team of professionals, as well as on the desktop.[16]

As for the question of home visit revealed in the speeches of the users, it is understood that this practice can become a rich moment, in which settles the movement, relations with the bug, the link and the qualified acceptance,[17] in addition to configure itself as an important health promotion strategy. However, many times, the medical professional presents some resistance to this type of activity, either by lack of professional preparation, personal predisposition, i.e. by the availability of time, because he knows the great demand of services and bureaucracy that the basic attention requires.

Users in their speeches complaints with regard to relationship issues reported it also with the health team professionals and other employees of the unit, showing the desire to changes of such professionals and management people who work and operate.

On these issues, it is necessary also increased investment in human resources through improvement and/or training staff, extrapolating only dimensions technical and introducing changes in cases of permanent education and training of health workers and established relationships, at work, for attention to the clientele.[18] This is a reality that can be configured as a strategy to pay for better service and user satisfaction with the service.

Before direct concern about the complaints and health problems that the customer will introduce ourselves, all health professionals that make up the family health team, need to be on the lookout for a good reception, open to hear doubts, pain and suffering, and the expectations of the subject you are looking for service, demonstrating commitment, care and education. Is a posture that can and relational tensions diminish that both weakened the health work in the search for the construction of a common outreach project that meets the needs of the community members.

From this understanding;

Face the challenge of building new foundations for development assistance in health practices puts us a bigger challenge, to deconstruct the arrays on which we, health workers, we were and still are formed.[19: 2005]

To do so, invest in a new movement of action on health allows us to pursue a process continuous construction, deconstruction and reconstruction of knowledge and practices, construction of a grouping in the team and of a collective project, in order to shift the attention of the team, production procedures for the production of watch.

As for the choice of ACS members of the unit, all of whom are residents of the neighborhood where the family health team, assumes that the share of advice of meanings and the use of everyday language of people facilitates the realization of mediations between technical and scientific knowledge and the popular. [20] However, what we see in the speeches of users is a great discomfort with ACS's performance of his community, expressing the need for greater engagement of these social actors.

It is important to recognize the performance of ACS within the team, having a critical eye regarding challenges and perspectives in the exercise of his act in the community, which runs more than a link, the ACS gives voice to the community, or is the voice of the community within the health services. Within the current context of macro health policy, one must look at the managerial level issues that could facilitate the work of the ACS with proposals based on identification and responsibility for the work, greater harmony with the health team, training for the better handling of situations that emerge from the community's everyday reality.

One of the innovative elements that the PSF introduces is the inclusion of the ACS in the health team, which has a strategic role for the consolidation of the SUS, since it facilitates the access of the population to health actions and services and represents the link between the teams and the community.[21]

The presence of the management responsible for the Organization and operated services and actions offered by the Health Unit cited as decisive factor for an improvement in the service to the population. The issue of management encompasses the need for integrated action between the various sectors that make up the network of primary health service organization, in addition to the urgent need to rethink articulation between the management model and the model of attention.

An important fact that needs to observe and that extrapolates the contents expressed in speeches is the matter of indications by third parties to ascend to the position of Manager. When the management process of a basic health Unit guided in a participatory management, warm, energizing, Resolute, which come to provide the construction of links, the changes appear as the result of a co-management work, where the community itself make up protagonist of a social context that seeks its resolutions sanitary problems and needs.

The basis of the rise should be the political, human and technical competence and a true spirit of leadership, which would overcome with disputes by micro powers within the inframunicipal sanitary territory and the selection to obey solids criteria, based on a profile established from the macro policies proposed by the municipal sanitary and administrative demands.[15]

Evidenced in some statements a concern with aspects related to infrastructure, organization and functioning of the Health Unit, for recognizing these issues as well as of fundamental importance when one considers a good health care:

Theme B – Improvement in infrastructure, organization and functioning of the Health Unit

The collective subject discourse: *[...] the breakdowns badly divided here. [...] the rooms, the tumultueiro of people there in that corridor [...] computerize, right, that was a lot better, things computerized. [...] reception be more informative, have some billboards, information on timetables, what are the medical services and the days of the week that service will offered to us. [...] What kind of service is offered, I would not require something that is not offered [...] meetings with the population on health service [...] enlarge the attendance of this post [...] I think you should take this Sabbath day, too.*

The infrastructure aspects of the USF commit the way users perceive the potential of the unit, as well as the inflexibility and rules of operation of the health unit and the absence of information that could be visualized through paintings of warning related to service demand, services provided and their schedules, and other actions taken by the team of health, hinder access, the efficaciousness and the smooth running of the Office.

The existence of a proper structure can positively influence health professionals ' practices, favoring better health care quality from the user. Moreover, surveys show that the impact of this structure of the service generates for the professional commitment of

their autonomy, dissatisfactions, wear and improvisations, conflicts with users, difficulty to plan resources and achieving goals, interruptions in the supply of shares.[22]

The testimonials emphasize that determinates actions that would facilitate and broaden the attendance were pointed out by users, as the investment in computer technologies for contributing to the reorganization of the space and working environment, allowing you to optimize and qualify for health care activities with the formulation of strategies and decision-making.

It is important to consider also that the need for expansion and flexibility of hours of operation of the health unit, expressed by users by choosing one day Saturday, may be indicating the need for adequacy of the services to the people, expanding the possibilities of access.[18]

Other prepass speeches by the desire for the existence of more medical specialties offered by Health Unit:

Theme C -Biomedical Model

The collective subject discourse: *[...] was also to have more doctors, huh! [...] Why isn't the only people here who come a lot of people from other communities [...]At least once a month to have a cardiologist there [...] I think I should have, psychologist, psychiatrist [...]*

Evidenced in the speeches as the population throws an expectation of care focused on medical specialties, the ancient features health centers. This refers to the fact that many basic health units are structured and functioning where once existed the so-called polyclinics secondary-level health care, without which this change has occurred with information and/or adjustments to that reality. Thus, it is clear as the – medical model, depending on economic, political and cultural interests, still stand in some regions and hegemonic countries.

An important fact is that the design of biomedical training of professionals is present in both understanding of community assisted but also reproduces inside the own health team. Polls show that the presence of these conceptions in the team to be attached to the training of biomedical professionals. Other evidence established for maintaining this conception in the imaginary collective social society is due perhaps to the few transformations that have occurred so far in the context of the training of professionals and that, in turn, influence the socio-cultural context of society.[9]

The clinic model is a strategy of action that needs to better rethink in the basic attention, with the concern to make a different hospital clinic, attentive to the subjective and social dimensions of health/disease process/care and worker process that it triggers and demand under the different realities. That means building therapeutic routes agreed upon between the user and the professional.[23]

Some lines have drawn attention to the need for a more sensitive and critical, on the part of professionals, to the community, revealing the lack of spaces for the exchange of information, through conducting group educational activities, mainly with teenagers and young people in the community:

Theme D -Health education

The collective subject discourse: *[...] need to have a different look to our community, our teenager's need a sexual orientation [...] need arise workshops free to work, huh! [...] wanted to close the station and make a nursery.*

Perceive themselves as users care about the fact of the existence of differentiated activities and renewed in health, so that provide moments of pleasure, reflection and learning, where concern over health care and the quality of life of the community become a priority and a right.

Particularly, he was appointed in the lines, a greater engagement with teenagers for being an age group marked by peculiar characteristics and life transformations, in addition to socializing with situations of vulnerability, as the violence, the world of drugs and trafficking, early sexual initiation and unprotected, STDs, lack of job opportunities. These situations require innovative strategies teaching and learning scenarios, reinventing educational practices that provide rescue these young people of their potential and abilities while active subjects within the process of social transformation.

Through the Dialogic and participative work that the educative actions in health are continuously renewed, giving stage to a care-educate based on understanding, habit, interaction, culture and values relating to the lives of people. To this end, in overcoming specific practices and linear, care is paramount to the professional health education process adopt, as a cheerful attitude in the face of life, actions and making fuss, diving in the culture and in the world who care, providing a critical reading of reality with the unveiling of situations that require changes and interventions.[24]

CONCLUSION

For realization of this work, he elected as goal met under the gaze of the users of the health service contributions of social participation in health planning. To do so, as it is a qualitative research, was established relations between the subject: researchers, community and health team professionals, through the insertion of the authors in the field during the investigative exercise, participating in the daily life in attendance by Health Unit, visiting streets and the various Community institutions with a view to observe their social dynamics.

A strong point evidenced by speeches was the issue of community leadership, needs to be strengthened through a political action-ethics-shared, citizen in that professionals and users are active in this process, recognizing themselves as allies within the complexity that involves health issues in the context of capitalism and private interests.

Thus, it is necessary that the people stay vigilant about intentionality and the true objectives of public policies within the dilemmas and challenges exceed by SUS,

participating as co-manager that needs to heard and have a say in decisions aimed at significant changes in reality.

Within a rigid system, normative and productive, often prevailing values disconnected from the collective, in defense of the hegemonic powers and not a people with access to services and humanized health actions, requires that the health professional break with conformity and submission postures realizing the user as a member of a community, as the leader of a people that needs to be actively heard, and, more, propose effective and efficient actions and charge. In order to commit to actions that exceed the simple assistance, realizing in their social context the limits and possibilities for health care, with due allowance for the individual in its entirety.

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