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Situational strategic planning in health and the approaches to worker's health in Family Health Strategy

Planejamento estratégico situacional em saúde: abordagem da saúde do trabalhador na Estratégia Saúde da Família

Planeamiento estratégico situacional en salud: abordaje de la salud del trabajador en la Estrategia Salud de la Familia

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Study using mixed methods and a constructionist social approach, aiming to analyze the use of Strategic Situational Health Planning to survey the demands related to worker health with two teams of the Family Health Strategy, from May to June 2018. We conducted an active observation of the territory, interviews with key informants, analysis of secondary data, and a group discussion. The teams had 1637 registered families, all the houses are made of brick, 80.1% have water treatment, and 99.6% receive their water supply through the public network. Garbage collection is public, 99.9% houses have a sewage system and 99.5% electricity. Active observation indicated a predominance of informal commerce. Social facilities were identified, such as churches, banks, community center for sports, public schools and a Reference Center for Social Assistance, as well as a public university. The residents of the areas covered are from the lower middle class, with people in a situation of poverty. Key informants reported that there are frequent household occupational activities among women of productive age. With regards to work-related illness, mental suffering and depression were identified as recurrent, as well as the absence of intersectorial actions. In the plan of action, the problem *"Arterial Hypertension, Diabetes Mellitus, and Mental Suffering as frequent diseases among working users"* was selected. The major issue selected for the elaboration of the action plan was *"Organization of the work process of the teams with weaknesses in the investigations / recognition of the health conditions of the working user"*. This study seeks to strengthen and build competences that lead to changes in the social reality of collectives, in line with the current Brazilian debate for the protection and promotion of health and for the prevention of damage to the health of workers.
Descriptors: Occupational health; Family Health Strategy; Community health planning; Diagnosis of health situation.

Estudo por métodos mistos e de abordagem construcionista social, com objetivo de analisar a condução do Planejamento Estratégico Situacional em saúde para levantamento das demandas relacionadas à saúde do trabalhador com duas equipes da Estratégia Saúde da Família, realizado de maio a junho de 2018. Realizou-se observação ativa do território, entrevista com informantes-chave, análise de dados secundários e roda de discussão. As equipes possuíam 1637 famílias cadastradas, todas as casas são de tijolo, 80,1% com tratamento da água em domicílio e 99,6% com abastecimento pela rede pública. A coleta do lixo é pública, 99,9% possui rede de esgoto e 99,5% energia elétrica. A observação ativa indicou predominância de comércio informal. Equipamentos sociais foram identificados, como igrejas, bancos, centro comunitário para prática desportiva, escolas públicas e um Centro de Referência para a Assistência Social, bem como uma universidade pública. As áreas de abrangência apresentam moradores de classe média baixa, com pessoas em situação de pobreza. Os informantes-chave relataram que existem atividades ocupacionais domiciliares frequentes entre as mulheres em idade produtiva. No adoecimento relacionado ao trabalho, o sofrimento mental e a depressão foram apontados como recorrentes, bem como a inexistência de ações intersetoriais. No plano de ação, optou-se pelo problema *"Hipertensão Arterial, Diabetes Mellitus e Sofrimentos Mentais como as doenças frequentes entre os usuários trabalhadores"*. O *nó-crítico* selecionado para a elaboração do plano de ação foi *"Organização do processo de trabalho das equipes com fragilidades nas investigações/reconhecimento das condições de saúde do usuário trabalhador"*. O estudo propõe o fortalecimento e a construção de competências que atuem na modificação da realidade social das coletividades, em consonância com o debate atual brasileiro para a proteção e promoção da saúde e para a prevenção de danos à saúde do trabalhador.
Descritores: Saúde do trabalhador; Estratégia Saúde da Família; Planejamento em saúde comunitária; Diagnóstico da situação de saúde.

Estudio por métodos mixtos y de abordaje construccionista social, con el objetivo de analizar la conducción del Planeamiento Estratégico Situacional en salud para levantamiento de las demandas relacionadas a la salud del trabajador con dos equipos de la Estrategia Salud de la Familia, realizado de mayo a junio de 2018. Se realizó observación activa del territorio, entrevista con informantes-clave, análisis de datos secundarios y ronda de discusión. Los equipos poseían 1637 familias registradas, todas las casas son de ladrillo, 80,1% con agua tratada en el domicilio y 99,6% con abastecimiento por la red pública. La colecta de la basura es pública, 99,9% posee red de cloaca y 99,5% energía eléctrica. La observación activa indicó un predominio del comercio informal. Equipamientos sociales fueron identificados, como iglesias, bancos, centro comunitario para práctica deportiva, escuelas públicas y un Centro de Referencia para Asistencia Social, así como una universidad pública. Las áreas de cobertura presentan residentes de clase media baja, con personas en situación de pobreza. Los informantes-clave relataron que existen actividades ocupacionales domiciliarias frecuentes entre las mujeres en edad productiva. En la enfermedad relacionada al trabajo, el sufrimiento mental y la depresión fueron apuntados como recurrentes, así como la inexistencia de acciones intersectoriales. En el plan de acción, se optó por el problema *"Hipertensión Arterial, Diabetes Mellitus y Sufrimientos Mentales como las enfermedades frecuentes entre los usuarios trabajadores"*. El *nudo-crítico* seleccionado para la elaboración del plan de acción fue *"Organización del proceso de trabajo de los equipos con fragilidades en las investigaciones/reconocimiento de las condiciones de salud del usuario trabajador"*. El estudio propone el fortalecimiento y la construcción de competencias que actúen en la modificación de la realidad social de las colectividades, en consonancia con el debate actual brasilero para la protección y promoción de la salud y para prevenir daños a la salud del trabajador.
Descriptores: Salud laboral. Estrategia de Salud Familiar; Planificación en salud comunitaria; Diagnóstico de la situación de sa

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INTRODUCTION

In Brazil, 30 years after the birth of the Single Health System (SUS), political and organizational strategies are required to consolidate and strengthen it[1,2]. The most recent example of this need is reflected in the 15th National Health Conference, held in 2015, whose motto was the defense of quality care as a right of the Brazilian people, and valued multidisciplinary and interdisciplinary work, transforming health practices[3].

The report from this conference showed the importance of maintaining universal social protection in health[3]. In this context, the expansion of the Family Health Strategy (FHS) was presented as a priority action to strengthen the SUS. Associated to the expansion of the FHS, the qualification of its work process is also crucial for promoting the comprehensiveness of health practices[1,2].

The reorganization of the functioning of the SUS health services network implies strengthening the administrative role of primary care through the FHS. As a level of preferential care, it should comprehensively attend the expanded health needs of the population and be organized by practices that are directed to the territorial social context of individuals, families and communities[1,2].

With regard to Workers' Health, a major advance in Brazil was its constitutional recognition as an area of public health[4]. However, reducing vulnerabilities related to environmental conditions and work processes has been an important challenge for SUS[4-6].

Shortcomings in the management of workers' health issues have been observed in the FHS, since no specific instrument is adopted to understand the work realities of the clients. This hinders the possible reflection of the teams on the relations between work and the health-disease processs[7], although the national policy of worker health of the SUS (PNSTT-SUS), by offering the conceptual bases and strategic guidelines to provide comprehensive care to workers, in order to be effective, reinforces the need for the engagement of primary care/FHS[4-6], proposing that the primary care teams/FHS should be able to recognize the health needs of the worker in the territories and overview situations of vulnerability and intersectorial actions in the face of these demands[4].

Thus, the health care of workers in primary care / FHS should consider an expanded understanding of labor processes in living territories, considering that work is a social determinant of the health-disease process. It is important that the teams know the occupational profiles of the territory under their responsibility, and monitoring the condition of this territory must be a part incorporated of their daily practice[5,6].

However, although the integration of Occupational Health actions in primary care / FHS is recognized as an necessary for the offer of comprehensive care, many of the team's activities are still focused on specific care actions to the demands[5,6] and on intervention practices, which are based on analyses of the population's health situation, planned and articulated according to local determinants for health conditions of the worker-user, but are often as incipient[4].

In the 1980s, the situational Strategic Planning (PES) was presented as a theoretical-methodological proposal to plan and govern, a facilitating method to generate the political viability of the plans. From this perspective, those who plan should be part of the reality with regards to which the plans are made as a historical practice. This requires dialog and interaction, because the diagnosis of the situation makes it possible to have control over the circumstances, not over an objective truth. The planning, here, understands that planned health propositions will lead to the resolution of health problems if based on the interpretation of the social determinants of the process of production of these problems[8,9].

In this context, there are concerns about the inclusion, in the PES, of communicative action elements, such as cooperation, negotiation, legitimacy, participatory engagement of social actors, and decentralization. This way of thinking is based on moments of open discussion, and through it, health planning becomes sensitive to the subjectivities of the population and becomes capable of understanding social contexts, not only by statistical abstraction. In

addition, the PES, as a technique, recognizes time as a resource, assuming that planning is an action that should have a fast and accessible character[8-10].

The PES is structured in key moments. In the first phase, the explanatory stage, a situational diagnosis is made, raising problems, prioritizing and defining major issues. Major issues are points in the system that are involved in the generation of one or more problems, thus helping to explain difficulties [9,10].

In the normative stage, the second one, objectives and results to be achieved are defined; strategies and actions that make it possible to overcome the major issues are established. At this stage, internal and external obstacles and opportunities are observed, the time required to solve the problems and the actions necessary to manage the plan are determined[9, 10].

In the strategic stage, the third one, the importance of the analysis of economic, administrative, and political resources required and/or available from the proposals outlined is emphasized. Finally, in the operational and tactical stage, proposals, schedules, resources, participants, and those responsible for actions are determined. In this stage, the indicators for monitoring the plan and its inclusive evaluation are discussed. This stage is necessary to adapt and adjust the directions being followed[9,10].

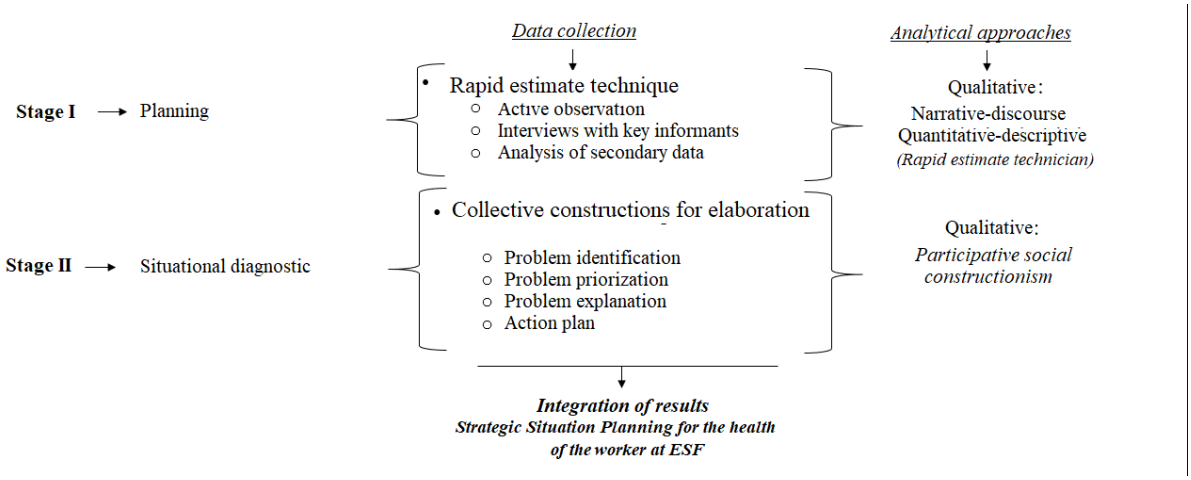
In this context, considering the planning of actions from the territory, and considering the health diagnosis, it is possible to understand the health situation according to determinants that are not only biological[5, 8], leading to the question: *How to carry out the PES in health, to address the health demands of workers in primary care/FHS?* Therefore, this study aims to analyze the execution of a Strategic Situational Planning in health to survey the demands related to worker health with teams of the Family Health Strategy.

METHOD

This is a mixed-method study. This type of study promotes the understanding of a phenomenon by associating quantitative and qualitative research methods, considering that an understanding of the phenomenon cannot be achieved by using only one of these approaches. The reliability of mixed-method researches is due to the organization of their stages, the association of the types of research and the theoretical framework (theorization)[11,12].

It is worth noting that, as a crucial stage of research involving mixed methods, it is necessary to integrate the results to give support to the answers of the study questions. Another important aspect is the need to express the steps of the research through an implementation matrix [11,13]. As shown in Figure 1, the transformative sequential perspective of mixed methods[11] was adopted as a strategy to carry out the research.

Figure 1 - Diagram of the structuring of the methodological path of the research, according to the perspective of mixed methods (implementation matrix). Uberaba, Minas Gerais, 2018.



The theoretical-methodological framework (theorization) was based on social constructionism, which seeks to understand the way in which people generate meanings about themselves and the world, building knowledge together with the actors involved, in a participative way[14].

Data collection took place between May and June 2018. Stage I was developed together with two FHS teams that usually carry out their activities by integration teaching and service, as they receive assistance by a school health center associated to the Universidade Federal do Triângulo Mineiro (UFTM). It was an intentional choice, due to the previous link between service and university, which makes it a viable space for the articulation intended by the study.

For Stage I, data collection was organized by the fast estimates technique [14], which includes: active observation, interviews with key informants, and the analysis of secondary data. Data collection followed scripts developed by the authors. In the active observation of the areas of coverage of the two FHS teams, the predominant type of productive activity, the social and community resources, and the areas of greatest vulnerability were considered.

Initially, the nurses responsible for the two teams were contacted to present the proposal and to invite all professionals. Nine Community Health Agents (CHAs) from both teams participated, who were present at the time of permanent education and were considered key informants because they were residents of the community, immersed in the daily life of the conditions that permeate the territory. Those on vacation or on leave at the time of collection were excluded.

The collection with the CHAs was organized on site. It was guided by a semi-structured interview containing questions about the most frequent occupations/professions among residents of the area, whether their jobs are formal or informal, what is the most common disease profile of workers in the area, and what type of work / workers fall most ill. The application of the instrument lasted 20 minutes.

Then, a discussion group was held with the CHAS, to expand the information on health actions. They were asked whether they usually ask questions about the user's work activity during the visits; if there is any articulation with the Occupational Health Reference Center (CEREST) of the locality; if the compulsory notification for Occupational Diseases has been completed. The discussion group lasted 90 minutes.

For the analysis of secondary data, records were obtained from the information systems of the teams for the sociodemographic and occupational characterization of the population of the area. Data provided by the teams were accessed (E-SUS System Report for the year 2017), supplemented by data from the coverage area provided by CEREST through the report on the profile of production determined in 2015.

Stage II was developed in an appropriate room at the university during the postgraduate course meetings. The analysis of the situational diagnosis (Stage I) was performed through a discussion group with the researchers.

Still in line with the procedural structure for the PES, there was a dialogue to determine the problems. These were given priority according to the FHS criteria of governance in dealing with them (values from 0 to 10 were given, the highest value being the highest level of governance), motivation/importance to propose actions (Outside/Little; Partial; Inside/Much), and according to criteria related to the urgency of each action's impact on the community (classified as low/intermediate/high)[13].

Next, the problem selected was described and explained by an analysis of the major issues. A interventions plan was elaborated collectively, that is, with the participation of all researchers during the discussion group. It resulted in a framework of actions to confront the priority major issues. Critical resources were identified for the implementation of the proposal. They were political (corresponding to negotiation with instances or sectors), administrative (financial, personal, or material resources), and cognitive (need to expand the team's expertise for management)[13].

As for the analyses undertaken during Stage I, numerical data were presented by descriptive statistics, records of active observation in narrative-discursive form, fragments of the discourses of the CHAs were used, and, to guarantee the secrecy and anonymity, they were coded using numbers (ACSn).

For Stage II, all the content discussed was recorded in a field notebook for later organization, transcription, integration of results, analysis, and to carry out the PES itself.

Regarding ethical aspects, the research was approved by the Research Ethics Committee of UFTM in 2017, under legal opinion No. 2,427,323. Data collection was carried out after the participants signed the Free and Informed Consent Form.

RESULTS

As for the situational diagnosis of workers' health in the FHS territory, active observation indicated a predominance of informal commerce, with establishments of different types, involving food market ("*mercadinhos*"), souvenir shops, including stationery stores, and small shops selling clothes, with pharmacies and dental offices. Still in the area, there are car repair shops and auto body shops, commerce during the night, including areas for prostitution, in addition to bars in various points of the neighborhood.

Social facilities were found, such as churches, banks, a community center for sports, and public schools. There is also a reference Center for Social Assistance (CRAS) in the region. The university itself is a social device of the adjacent area.

In general, the areas of coverage have the features of territories with lower middle class residents and sectors more focused on the territory, with people in poverty. The conformation of the areas of coverage allows micro-areas to be further away from social resources, impressing greater vulnerabilities to this more peripheral population.

The nine key informants who participated reported that the most common professions in the area are in small shops, in addition to maids and construction workers, such as masons and mason's assistants. The latter two perform their labor activities outside the neighborhood.

Women of productive age frequently work from their own houses. They make takeaway food or other foods, cakes, and snacks; sell cosmetic products at home; in addition to those who are manicures and hairdressers, working in the backyards of their homes.

They mentioned that, during the night, young people and adults form crowds, consuming alcoholic beverages, in spots such as bars, providing some contact between partners, there is prostitution in specific places during the night.

The issue of drug trafficking in the region was alerted by the CHAs, who reported the existence of pre-adolescents and adolescents involved in the sale. In the speeches, they mentioned areas in the territory delimited for the" trade " of drugs.

There are, as reported, impositions by criminals, with recurrent thefts to individuals and local commerce, which ends up suppressing the free traffic of people in the squares and other places of the territory, especially at night.

With regards to work-related illnesses among the population of the area of coverage, key informants expressed mental suffering and depression as recurrent in the population of the assigned area:

[...] Mental fatigue, we see a lot of workers complaining about it (ACS_1).

Workers seek the service to treat hypertension and diabetes, noticing that these diseases have expanded among the adult working population. However, when discussing the health situation of the workers in the area of coverage, the CHAs also discussed the precariousness involving their own health and work conditions. [...] I myself was on leave with a diagnosis of depression for four months that the government system did not accept, so it was an unpaid leave. Here you are forbidden to get sick (ACS_2).

The key informants did not point out intersectoral actions articulated with FHS teams for the promotion of workers' health, nor the organization of local protection networks. The articulation of representatives for participation in the decision-making and evaluation processes of the school health center, such as the creation of the Local Health Council, was not

mentioned. Also, with regards to the organization of the health service to meet the needs of the user-worker, weaknesses were found in the operationalization of the daily activities of both teams:

[...] The application of health policies, many do not happen (ACS$_3$).

Sex workers were not seen, in the discourse of key informants, as a category that needs specific care - the embracing of their demands was omitted with silent negligence.

Participants also reported not having, in their daily routines, the practice of filling out the notifications of work-related diseases. They discussed that, in the unit, there is no specific type of reception or specific activity to address the issues of the working user, such as a third shift of care, and that there are interactions with the regional CEREST, but these are often informative-normative. They could not point to meetings to raise issues about the context or plan joint actions.

Regarding the analysis of secondary data, according to the data of the E-SUS, the teams have 1637 registered families (ESF$_1$ = 800; ESF$_2$ = 837). As for the physical structure of the areas, 80.1% of the houses have water treatment at home. Houses receive their water supply from the public network in 99.6% of homes. All houses are made of brick and 99.5% have electricity. The garbage is removed by public collection services and 99.9% of the houses have sewage systems.

The most common professions were: hairdresser, cook, manicure, maid, bricklayer, and salesman, activities that generally require a lower educational level or no specialization.

Table 1. Characterization of the population in the area of coverage of the FHS teams regarding their productive profile. Uberaba, Minas Gerais, 2018.

Aspects of the productive profile[a]	Teams	
	FHS1 (n)	**FHS2**(n)
Families who participated in the productive profile		
Families registered in the FHS	800	837
Families interviewed	629	837
People who participated in the productive profile		
Participants	2911	2915
Participants of working age	2371	2310
Participants who reported informal work	51	47

Source: Uberaba, Municipal Health Secretariat, CEREST, productive profile, 2015.

According to the analysis of the situational diagnosis, the collective constructions for the PES in occupational health in the territory of the FHS allowed the design of five macro-problems related to the social-territorial context of study (Chart 1).

Chart 1. Identification and prioritization of problems related to workers' health in the population in the area of coverage of the FHS teams, according to a situational diagnosis. Uberaba, Minas Gerais, 2018.

Problems identified	Governance	Urgency	Motivation
Local intersectoral network with non-existent or fragile links to promote actions for workers' health.	5	Mean	Partial
Productive activities, according to profile, related to occupations with low education, resulting in underemployment.	1	Low	Outside/ Little
Drug trafficking being a source of income for pre-teens and teens.	4	High	Partial
Arterial hypertension, Diabetes Mellitus, and mental suffering as frequent diseases among working users.	7	High	Inside/ High
Organization of the work process of the FHS teams has shortcomings in the execution of investigations / recognition of the health conditions of the worker user.	8	Intermediate	Inside/ High

For the elaboration of the action plan, the problem *"Arterial Hypertension, Diabetes Mellitus, and mental suffering as the frequent diseases among working users"* was given priority. This problem is explained, according to the report of the key informants, as a recurring problem among users-workers, assisted by the FHS, because it is a reality in relation to which the group of researchers presented greater governance and motivation for intervention.

Thus, the major issue selected for the elaboration of the action plan was *"Organization of the work process of the FHS teams with shortcomings in the investigation/recognition of the health conditions of the worker user"*. Regarding the action plan, initiatives were defined that could be implemented in the study setting (Chart 2).

Chart 2. Action plan to address the problems related to the health of workers in the population of the FHS teams, according to a situational diagnosis. Uberaba, Minas Gerais, 2018.

Major issue: *Organization of the work process of the FHS teams has shortcomings in the execution of investigations / recognition of the health conditions of the worker user.*	
Actions	**Critical resource**
Share the situational diagnosis with the FHS teams for discussions and for the collective elaboration of the action plan.	- Political: authorization from superiors to hold the meeting.
To sensitize all FHS team regarding the importance of compulsory notification of work-related diseases.	- Political: authorization from superiors to hold the meeting. - Cognitive: organization of actions to raise awareness.
To develop informative materials on the actions of the social equipment of the area of coverage, including the University, regarding the provision of initiatives for professional qualification and for the "healthcare of the worker".	- Cognitive: elaboration of the informative materials. - Administrative: identification of local social devices and resources available (mapping).
To carry out activities with key informants (CHAs) on practices for health care and for the management of everyday issues related to their work.	- Political: authorization from superiors to hold the meeting. - Cognitive: organization of actions to raise awareness.

DISCUSSION

In order to structure the practices in the context of the FHS, it is a priority to recognize the territory as a social space where society is built and rebuilt according to its core work and production process, dividing itself into different classes, resulting in unequal access to health services and consumer goods[15-17].

Social vulnerability is understood as the overlap of social and environmental risks that are concentrated on certain areas and worsen situations of poverty and other issues. The reality

discussed in this study coincides with existing realities in many Brazilian peripheral and peri-urban areas[15, 16].

It is evident that, since its implementation, the FHS had, as its objective, offering care to areas of greatest social vulnerability. However, the interaction between FHS teams and the community meant they needed to prepare to face adversities relative to the context of the territories approached, such as violence and other vulnerabilities expressed by social inequalities[15-17].

There are important gaps in the action of the teams regarding the circumstances of the PES and the health of the worker in primary care / FHS. In general, the situational diagnosis of workers' health has not been considered in the planning of the actions[18]. The actions of the PNSTT-SUS, developed by the CEREST, spontaneously or normally, have not been sufficient for integration between these services and the primary care/ESF teams[19].

When the inclusion of workers' health in primary care / FHS does not consider the health of workers themselves and their professional activities, that is a limitation in the services. In this dimension, shortcomings can be observed regarding their formation, in addition to the absence of institutional support in the establishment of lines of care in this theme. Structural difficulties are persistent in primary care / FHS, highlighting the precariousness of the physical and computer network [18,19].

The establishment of the relationship between work and the complaints/illnesses presented by the user-worker make it possible to reveal the contribution of work in the health-disease process and to guide the actions to be taken[20,21].

It is important to recognize the worker user and establish the relationship between work and health-disease conditions, since, in the current Brazilian socioeconomic context, many workers have informal and / or precarious jobs, or are unemployed and in a situation of social vulnerability. In many cases, they develop productive activities at home or near their houses periodomycily[20,21].

The PNSTT-SUS highlights the importance of analyzing the health situation of workers in the territorial context, especially to guide the identification of users and the most vulnerable groups, such as the unemployed and those involved in productive activities at home and / or in informal and precarious work relationships, or exposed to activities that are dangerous to their health[20].

The CERESTs have an important role as institutions that give support to actions. They are references in the work process of primary care/FHS teams, seeking to identify appropriate strategies so that characteristics and organizations of health practices of primary care / FHS teams favor the access of workers to health care with quality and resolution, potentially understanding the mechanisms by which their work influences their living and health conditions[20,21].

As for the network of major issues, direct interferences related to the work process of FHS teams was prioritized, leading to a distance from the needs of the working population. Simultaneously, the organization of the work process has limited intersectorial articulation with the local network. This articulation could offer expanded protection to worker users, including the possibility of enabling, through the association of the network, opportunities for technical qualification and increased education of the population of worker users, enabling them to search better positions in the job market.

The organization, mode and process of work of the FHS teams do not encourage the approach to the needs of the working users, hindering social engagement and democratic-participatory action with the health service. The lack of social mobilization of worker users limits the possibilities of dealing with of issues such as crime and drug trafficking, meaning that the daily life of this population will remain to be affected by this reality of violence.

The validation and sharing of situational diagnoses with FHS teams is a crucial initiative, and the result presented in this study are a first perspective to be induced in the territory. The

respect for the PES framework of dialogue and engagement with the social actors involved in the setting with regards to which the plan is to be made is crucial for the implementation of the plan to have political viability [22-24].

It must be taken into account that a social actor with knowledge of the problems and the ability to reason strategically will most likely deal with problems better than someone with low knowledge about the reality, who only has methodological knowledge[22-26].

Especially after the situational diagnosis in health, it was possible to identify the need for actions aimed at the specificities of everyday life in communities, leading the plan to include ad hoc initiatives, specific to the social contexts, through the interest of the actors engaged in them[23,24].

Considering the territory as an operational base for the planning of actions and incorporation of problems arising from the relations of production and work in an integrated action in primary care / FHS have been discussed as highly viable initiatives. Therefore, they help to organize strategic actions that contribute to the materialization of workers' health promotion, as pointed out by experience reports[23-25].

Although there are problems, which were found by the situational analysis, there are other resources in the study territory, such as social devices that can contribute from the promotion of workers' health. Therefore, the federal public university, one of the social facilities of the territory, has, as one of its missions, to support the implementation of initiatives, through the integration of teaching with the offering of services that favor integral care and the surveillance of workers' health in the territories.

PES initiatives, as a strategy for teaching-service integration in the FHS, have been reproduced in training scenarios, in order to encourage students to discuss public health issues. Practical classes have also been offered to help recognizing different settings for analyzing health situations.

CONCLUSION

This study analyzed the development of the PES in health. It was divided in the stages of diagnosis of the health situation and collective constructions for planning. In addition, it enabled an approximation with the reality of worker users, who mostly have informal jobs that require low education, and use their homes as spaces for productive activities. In addition to this, drug trafficking, prostitution, and the impositions of criminality could be observed, a reality which resembles that of many peripheral areas in Brazil.

Regarding the planning itself, it was shown as major issue in the organization of the work process of the FHS teams approached. This process has shortcomings for the investigation of the health conditions of the worker user.

The implementation of intersectorial actions of social engagement, for participatory mobilization and surveillance of the health conditions of the worker user, are connected to the ways to deal with the major issue reported.

The planning was developed as a teaching-service integration activity. Therefore, it is necessary to share the situational diagnosis with the FHS teams, in addition to the need to evaluate, in future researches, the impact of the actions planned for the teams and the community.

Limitations of this study are the impossibility of generalizations, due to the specificities of the analysis territory. However, it was possible to understand health practices aimed at the worker user in the context of the FHS and the need to re-signify actions to promote and monitor worker health in the community.

This study also recognizes its shortcomings in the fact that the perception of other key informants about the territory was not included. However, the aspects concerning the work of CHAs, since they are immersed in the daily life of the territories, not to mention that they

residents of the area, legitimize their participation as actors that are adequate for the objectives of this research.

The fact that the collective constructions were developed only in the training scenario may be another limitation, which should be addressed in later studies when the results are shared with the FHS teams. As stated in the plan, the expansion of the discussion with the other social actors of the studied territory should be articulated.

The potential contributions of this study are presented as incentives for similar activities to be reproduced in health education, in order to reinforce the construction of competencies that act in modifying the social reality of collectivities, in line with the current Brazilian debate on the need to defend and strengthen the mission of SUS to protect and promote health and prevent damage to the health of workers.

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Fernanda Carolina Camargo and **Isabel Aparecida Porcatti de Walsh** contributed to the conception, design, analysis, and interpretation of data, writing and revision. **Gabriela Gonçalves Machado**, **Luana Rodrigues Rosseto Felipe**, **Gabriela Souza Faria**, **Ana Laura Nogueira,** and **Sandra Cristina Romano Marquez Reis** contributed to the conception, design, analysis, and interpretation of data, writing and revision.

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