REME • Rev Min Enferm. 2020;24:e-1299
DOI: 10.5935/1415-2762.20200029

RESEARCH

THE HEALTH NEEDS OF USERS AND THEIR INTERACTION WITH PRIMARY CARE

AS NECESSIDADES EM SAÚDE DE USUÁRIOS E SUA INTERAÇÃO COM A ATENÇÃO PRIMÁRIA

NECESIDADES DE SALUD DEL USUARIO Y SU INTERACCIÓN CON LA ATENCIÓN PRIMARIA

Elaine Miguel Delvivo Farão [1]
Cláudia Maria de Mattos Penna [2]

[1] Universidade Federal de Minas Gerais - UFMG, Programa de Pós-Graduação em Enfermagem. Belo Horizonte, MG - Brazil. Fundação Universidade Federal do Mato Grosso do Sul - UFMS, Curso de Enfermagem. Coxim, MS - Brazil.
[2] UFMG, Programa de Pós-Graduação em Enfermagem. Belo Horizonte, MG - Brazil.

Corresponding author: Elaine Miguel Delvivo Farão
E-mail: elainebiofis@yahoo.com.br

Author's Contributions::
Conceptualization: Elaine M. D. Farão, Cláudia M. M. Penna; **Data Collection:** Elaine M. D. Farão; **Investigation:** Elaine M. D. Farão; **Methodology:** Elaine M. D. Farão, Cláudia M. M. Penna; **Project Management:** Cláudia M. M. Penna; **Statistical Analysis:** Elaine M. D. Farão, Cláudia M. M. Penna; **Supervision:** Cláudia M. M. Penna; **Visualization:** Elaine M. D. Farão; **Writing – Original Draft Preparation:** Elaine M. D. Farão; **Writing – Review and Editing:** Cláudia M. M. Penna

Funding: No funding.

Submitted on: 2019/09/03
Approved on: 2020/01/17

ABSTRACT

Objective: to understand the meaning of health needs in daily life for users of primary health care. **Method:** it is a qualitative research whose theoretical framework was symbolic interactionism, and the methodological one was the theory based on the data. 23 users of primary health care in the city of *Coxim*-MS were interviewed, from February to November 2018. The interviews were recorded, transcribed and analyzed, with the analysis concomitant with data collection. The duration of the interviews was, on average, one hour. Initially, the participants were randomly selected. During the analysis of the data, sample groups were created, with the purpose of increasing the variability of conceptions about the phenomenon. The data were analyzed using open, axial and selective coding. **Results:** the health needs of everyday life result from the interconnection of three subcategories, as follows: the first, called "self-care: taking care of what I could take care of" - self; the second, "relationships in society - interaction with the other"; and the last, "the relations with the space where one lives - the interaction with the environment". **Conclusion:** it was found that the needs of everyday life are not meant in an interactionist perspective, by users, as demands that can be taken care of in the services. Thus, as they distance themselves from biological demands, they are neglected by health professionals in primary care and reflect that comprehensive care still remains a challenge within the scope of the Unified Health System (*Sistema Único de Saúde-SUS*).

Keywords: Health Services Needs and Demand; Integrality in Health; Primary Health Care; Health Promotion; Nursing.

RESUMO

Objetivo: *compreender o significado das necessidades em saúde da vida cotidiana para os usuários da atenção primária à saúde.* **Método:** *trata-se de pesquisa qualitativa cujo referencial teórico foi o interacionismo simbólico, e o metodológico foi a teoria fundamentada nos dados. Foram entrevistados 23 usuários da atenção primária à saúde do município de Coxim-MS, no período de fevereiro a novembro de 2018. As entrevistas foram gravadas, transcritas e analisadas, sendo a análise concomitante a coleta de dados. A duração das entrevistas foi, em média, de uma hora. Inicialmente os participantes foram selecionados aleatoriamente. No decorrer da análise dos dados, foram sendo constituídos os grupos amostrais, com a finalidade de ampliar a variabilidade das concepções sobre o fenômeno. Os dados foram analisados por meio da codificação aberta, axial e seletiva.* **Resultados:** *as necessidades em saúde da vida cotidiana resultam da interconexão de três subcategorias, a seguir: a primeira, denominada "o autocuidado: cuidando do que eu podia cuidar" – self; a segunda, "os relacionamentos na sociedade – a interação com o outro"; e a última, "as relações com o espaço onde se vive – a interação com o ambiente".* **Conclusão:** *constatou-se que as necessidades da vida cotidiana*

How to cite this article:
Farão EMD, Penna CMM. The health needs of users and their interaction with primary care. REME - Rev Min Enferm. 2020[cited _____ ____ __];24:e-1299. Available from: _____ DOI: 10.5935/1415-2762.20200029

não são significadas em uma perspectiva interacionista, pelos usuários, como demandas que podem ser cuidadas nos serviços. Dessa forma, por se distanciarem das demandas biológicas, são negligenciadas pelos profissionais de saúde na atenção primária e refletem que o cuidado integral ainda permanece como desafio no âmbito do Sistema Único de Saúde.

Palavras-chave: *Necessidades e Demandas de Serviços de Saúde; Integralidade em Saúde; Atenção Primária à Saúde; Promoção da Saúde; Enfermagem.*

RESUMEN

Objetivo: *entender el significado de las necesidades cotidianas de salud de los usuarios de atención primaria.* ***Método:*** *investigación cualitativa cuyo marco teórico fue el interaccionismo simbólico y el metodológico la teoría basada en datos. Se entrevistó a 23 usuarios de atención primaria de salud de la ciudad de Coxim-MS, de febrero a noviembre de 2018. Las entrevistas fueron grabadas, transcritas y analizadas. Proceso de recogida y análisis de datos. La duración de las entrevistas fue, en promedio, de una hora. Inicialmente, los participantes fueron seleccionados al azar. Durante el análisis de datos se crearon grupos de muestra con el propósito de aumentar la variabilidad de conceptos del fenómeno. Los datos se analizaron mediante codificación abierta, axial y selectiva.* ***Resultados:*** *las necesidades de salud de la vida cotidiana son resultado de la interconexión de tres subcategorías: la primera, llamada "autocuidado: cuidar de lo que yo podría cuidar" - auto; la segunda, "las relaciones en la sociedad - la interacción con el otro"; y la última, "las relaciones con el espacio dónde se vive: la interacción con el entorno".* ***Conclusión:*** *se constató que los usuarios no les dan a las necesidades del día a día el significado, desde una perspectiva interaccionista, de demandas que pueden ser atendidas en los servicios. Por lo tanto, a medida dejan de ser demandas biológicas, los profesionales de la salud de la atención primaria las descuidan, lo cual muestra que la atención integral sigue siendo un reto para el alcance del Sistema Único de Salud.*

Palabras clave*: Necesidades y Demandas de Servicios de Salud; Integralidad en Salud; Atención Primaria de Salud; Promoción de la Salud; Enfermería.*

INTRODUCTION

The health needs of populations have been the subject of research, serving as reflections that support the construction of public care policies.[1]

The planning of these policies, as well as the operationalization of the care network, is carried out by professionals, whether they are managers, care professionals or from other areas that involve scientific knowledge. Organizational guidelines are outlined through the health professionals' worldview both in health services and in the elaboration of laws and guidelines that guide SUS management.[2,3]

The health needs are mentioned in the plans and guidelines, but the meaning considered for the users' needs by the professionals is not explained. Thus, the question is: how do these services and actions available dialogue with the search for care carried out by the system user? What happens in the care microspaces, either in the health unit or at home? What care do people look for when attending services?

The dynamics of work in health care services is focused on the cure and rehabilitation of sick people, reducing health needs in biological demands.[3,4]

In a study carried out with health professionals, the results show that the users' health needs may be visible or invisible to the professional's view, the former being those that correspond to the demands centered on the body and on people's illness processes and are prioritized by health care. The latter, on the other hand, are those that distance themselves from biological issues and do not require care from health services, being responsibilities of other sectors of society.[5]

Corroborating, research shows that the services offered in primary health care (PHC) are focused on the disease and the medicalization of the problems presented by users, with the concept of health needs, summarized in the daily practice of services, the demands of pathophysiological processes that involve illness.[3-5]

However, for the construction of singular therapeutic projects, which in fact achieve comprehensive care, with health promotion, it is necessary to hear the voice of users of the Unified Health System (Sistema Único de Saúde - SUS) and mobilize efforts so that they participate in the care planning.

Thus, the following questions guided the realization of this study: what is the meaning of health need for PHC users? What do they look for when looking for health services?

Thus, this article aims to understand the meaning of health needs in everyday life for PHC users.

It is stated, as an assumption of this study, that health needs originate from people's experiences in singular daily lives, however these subjective needs are not always accepted by health services.

METHOD

This is a qualitative study, whose methodological framework adopted was the grounded theory (GT), in the theoretical light of symbolic interactionism (SI).[6-8]

The SI constituted itself as a theoretical reference for the study, because it allows to understand the way people act in society, their interpretation of the phenomena, the interaction with the Other and with the world around them. In society, social interaction is not restricted to the Other, but adds to the self-interaction called self.[6,7] Human actions and behaviors are the result of these interactions in a space experienced by people. Complex thinking derived from interactions and resulting in actions is termed in the interactionist perspective of Mind.[6,7]

The research was carried out in a Family Health Strategy (FHS) in the city of *Coxim*, in the interior of *Mato Grosso do Sul* State, which serves approximately 2,735 people, distributed in seven micro areas, four of which are covered by a community health agent (CHA).

The criteria for inclusion in the study were: accepting to participate voluntarily in the research, being 18 years of age or older, belonging to one of the four micro areas covered by CHA.

For the start of data collection, the following questions were asked: what does health mean to you? What does disease mean to you? And what do you look for when using health services? As the data was being analyzed, new questions were being established to better understand the participants' conceptions about health needs and to deepen the properties and dimension of the categories.[8]

Initially, open sampling was performed, with women with children (group A) being randomly interviewed, as they characterize the most expressive audience in the FHS that constitutes the study scenario. After initial analysis of the first interviews, two sample groups were created, for the purpose of constant comparison between the data, people with chronic diseases (group B) and people without chronic diseases (group C) related to the FHS.

Subsequently, for the refinement of the developed theory, a new sample group was created with people belonging to religious denominations (group D), in view of the phenomenon of spirituality being addressed and related to health needs by the participants. It is noteworthy that in GT sampling is intentional, making it possible to expand the possibilities of deepening the data and comparative analysis.[8]

Twenty-three FHS users were interviewed. The age in years of the participants varied between 18 and 91, which contributed to diversify the ways of looking at the phenomenon from experiences in different historical-social contexts.

Data were collected from February to November 2018, when the theoretical data saturation occurred, which happens when there is depth in the analysis, in such a way that the theory is consistent.[8]

When the methodological framework is GT, the analysis is carried out right after each interview, leading to the creation of sample groups to deepen the theoretical constructs that constitute the studied theory.[8]

During the conduct of the study, memos were prepared containing the records of the decisions taken in the process of collecting and analyzing the data, as well as the questions that led to the constitution of the sample groups and the questions addressed to the participants.[8]

The analysis was carried out in three stages, presented, didactically, in a linear way: open data coding, axial coding and selective coding.[8]

In open coding, the conceptual data was named with a short word or phrase, which expressed the meaning of these for the researcher and indicated the observed phenomenon. After the open coding of the interviews of sample group A, it was observed that some women who resort to health services in PHC often have chronic diseases. So, it is questioned how is the relationship between chronic illness, care and health needs in everyday life? How do these codes relate? Is there a difference between the conceptualization of participants with chronic diseases and the conceptualization of people who do not have any disease?

In order to answer these questions, groups B and C were created, enabling the deepening of concepts and the constitution of categories through axial coding. In axial coding, codes built on open coding, such as, for example, "relational health" and "financial health", were rearranged giving rise to those that were more abstract and that expressed broader concepts.

A comparative analysis process was carried out between each interview analyzed, in which the similarities between the properties of the codes created and the possibility of grouping were identified, aiming at the construction of the categories.

Spirituality is a phenomenon evidenced by the participants from group A. Thus, as the records in the memos demonstrate the strengthening of this concept in groups B and C, but there are still gaps to be filled, there is a need for the constitution of group D, which allows the selective coding and refinement of the theory with the integration between the constructed categories. It is noteworthy that during the whole process of comparative analysis of the data, the questions recorded in memoranda were fundamental to conduct the other data collections and enable theoretical deepening.

From the data analysis, the following categories were highlighted: *the needs of everyday life; the "relationship with the transcendent" as a support in the care of health needs; the affected needs - reasons for seeking care and the ways of seeking care in illness*. In this study, data related to the first category are presented and discussed, which deals with health needs that are typical of everyday life.

To preserve the identity of the participants, their names were replaced by words that refer to the flora and fauna of the *Pantanal* in *Mato Grosso do Sul* State, followed by the number that indicates the order in which the interview was carried out and then the characterization of the sample group from which the interview was part of (Babaçu 14, group B).

The regulations of Resolution Nr. 466/2012 of the National Health Council (*Conselho Nacional de Saúde*-CNS) were followed, which regulates the conduct of research with human beings in Brazil, and the Informed Consent Term (ICF) is offered in two copies of equal content, signed by the researcher and interviewed. Data collection started after approval by the UFMG Research

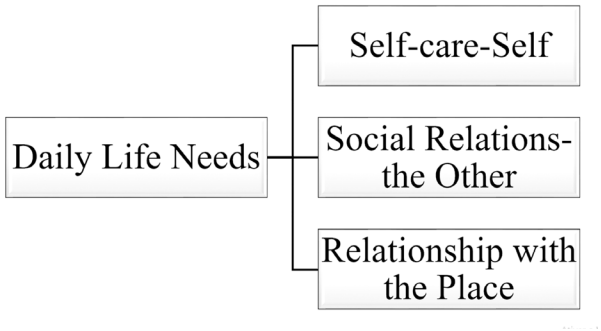

Figure 1 - Definition of the first category: the needs of everyday life. Source: research data, 2018.

Ethics Committee, under registration number at Plataforma Brasil - CAAE 41899115.0.0000.5149 and Approval Opinion Report Nr. 2,361,508/2017.

RESULTS

In this presentation of results, the properties that make up the categories are presented in bold and the *in vivo* codes written in italics. The properties are constituents of the categories and subcategories unveiled, as they are central characteristics of the studied phenomenon. *In vivo* codes are concepts entitled by means of fragments taken from the participants' speeches. During the analysis of the data diagrams were built that contribute to work out the relationship between the concepts that underlie the theory developed.[8]

The results of this research were built on a theory about the meaning of health needs for PHC users, with the category "health needs of everyday life" constituting this theory and summarized in the diagram below:

It is evident that the subcategories constituting the phenomenon studied in an interactionist perspective are: the first, called "self-care: *taking care of what I could take care of - self*"; the second, entitled "relationships in society - interaction with others"; and the third, "the relations with the place where one lives - the interaction with the environment". They were built in a related way through the axial analysis of the data, however, didactically are presented separately, for a better understanding of the studied phenomenon.

First Subcategory: Self-care: taking care of what I could take care of - self

People encounter experiences in a space and time in which they develop relationships influencing actions and being influenced by others, in society. In an interactionist perspective, actions are not mere chance or simply reflexive responses. People synthesize a complex thought in the Mind and in the relationship with themselves, called self, being a constituent of behaviors in society.[6]

The first subcategory constructed highlights the relationships of people with themselves, - self. Thus, the conceptions produced by Mind in search of healthy living are meant by the subjects and expressed in the self-care exercised in daily life.

This category can be conceptualized by properties that symbolize people's self-interaction to live with health and quality of life. Thus, **life habits** and **financial condition** are considered, influencing and constituting behavior in society.

The care with food and physical activities express consequences of reflection in the Mind of people on the actions that can be performed by them, with autonomy for self-care.

> *Chosen foods, preferably natural, vegetables, fruits, greens all help us in the matter of physical health nutrition [...]. Everything is prevention, breast cancer is prevention and AIDS is prevention. It is taking care of your body, everything that is too much is bad, even water if you take too much you get intoxicated, everything is prevention, everything is balance. From what I eat to the amount I eat, the quality of what I'm eating, everything is prevention* (Aroeira, 09 - Group C).

The analysis of the data denotes care with the quantity and quality of food, as actions that express people's concerns with themselves in the exercise of care in search of living healthily.

> *I use the gym, do pilates, do water aerobics, walk, be careful with food, be very careful with what I do. In my house, it is strict, there is no candy here, that dessert, no pasta access and these little things more* (Mandovi 06 - Group B).

In addition to the search for a balanced diet, the practice of physical and sports activities is considered a lifestyle habit that provides well-being and quality of life, contributing to the prevention of diseases. Regarding food, the use of what is natural and slight industrialized is symbolically represented by people as important to life with health and well-being.

> *A good diet maintains the person, the human body needs good nutrition, it needs well-being (Pequi 15 - Group C).*

The concern with healthy living habits is expressed in the care of oneself and in the attention to family members who are part of daily living, with the family adopting a posture of care for food at home.

> *Eating fruits, greens and my family's education from the beginning is with this regulated diet, so I don't miss meat, I avoid cheese (Tambaqui 18 - Group C).*

For the study participants, the control of what is consumed at home with the search for healthy habits needs to be followed by the whole family. In the Minds of people, the introduction of teas and herbs in the diet is a culturally accepted practice and is motivated in the community by the experienced benefits of eating natural products, providing a sense of well-being.

> *Then I was making homemade tea for her. [...] then I picked mint, arnica, Creole cotton, what I gave her a lot was that cocoon of Creole cotton, thank God it improved a lot* (Seriguela 11 - Group B).

It is also noted that the habit of consuming teas and herbs is passed from generation to generation, being part of the culture of care and in the daily lives of *Coxim* residents.

> *I use "sabiquira", which is a seed in which its oil is a little bitter, you know, it whets your appetite and cleanses the intestines, cleanses the skin, right? So, I know very well that it is strong. So, I knead one and put it in water and gradually give it to the baby to drink it diluted, with plenty of water, because I know it is strong. [...] my daughter, who is seven years old, has had this tea since she was five, I think* (Jenipapo 23 - Group D).

The inclusion of teas and natural herbs as products that enrich the diet takes on meanings of improving the functioning of the organism, such as improving appetite, intestinal transit, being significant to enhance the health of the physical body, both for children and adults.

In order to acquire healthier food, to honor the financial commitments related to living in society, the **financial condition** is revealed as a property that varies in size between sufficient and insufficient for the maintenance of families, which may contribute to people's illness.

> *I am different from that, if I owe [debts] I don't sleep, I have no appetite to eat. For me, the health part is very important. I know people who work hard to buy some rice, but it is difficult, but God is so great, that I turn back and forth, but I manage, but I am able to bring at least something to the house* (Babaçu 14 - Group B).

The insufficiency of money to pay debts influences other nuances in life, such as the quality of sleep and the willingness to eat, impacting people's quality of life.

> *There are some people [...] that the bad financial situation totally affects health, sleep, which is related to health, so, like this, it interferes and very negatively. However, in this way, if the person is able to pay the bills and survive, buy something that is not so superfluous, you do not need to earn a lot for you to be happy, well, healthy* (Araçá 22 - Group D).

For the participants, survival in society is related to the financial situation, which may contribute to people's health or enhance illness.

In the exercise of self-care throughout life, people see the need for professional assistance, however, barriers to access in the public health care network exist, and the **financial condition** also influences the user's ability to use private health services when it is impossible to access the services offered in the municipality by SUS.

> *Yes, if the person has money they will not be subjected to these healthy units, go to the doctor, go to the place that has comfort, you have money, if you don't have it, the main thing is health and another is money* (Seriguela11 - Group B).

> *The woman from the Health Department said that in about three years you will get a neurologist. I said: until then I am already dead, because if you have money you go to the doctor, you are assisted, able to do the exams* (Cambarás 16 - Group B).

Agility in care and in solving problems related to illness can be achieved when people have the financial possibilities to use private health care services.

> *As I said, if it is my responsibility to be healthy, I have to have the resources to seek health in general, either by purchasing more healthy foods that are a bit expensive, even paying for expensive surgery, if necessary* (Heliconia 19 - Group D).

> *It interferes with health, for example, if I was not able to go to Campo Grande when I had a problem with my breast, at the time a migraine appears, therefore, it already has become something else* (Babaçu 14 - Group B).

In the municipality where the study was carried out, the reference for emergency care and specialties is located at a distance of approximately 295 km. In this context, the **financial condition** interferes with the supply of personal needs to remain in another municipality, such as lodging, transportation, access to medicines not available in SUS, supplies for care or food.

In addition to the interaction with yourself - self, represented in this analysis by **self-care,** people interact symbolically with the Other in their daily lives, which is a relationship that constitutes

health needs. The properties of relationships in society are discussed in the second subcategory, below.

Second Subcategory: Social relations – the Other

Social relations are necessary and part of the everyday reality of people's lives. However, depending on the interaction in the **social relationships** built in this **coexistence,** the impacts felt on people's quality of life may be more positive, resulting from social relationships symbolized as harmonic, or more negative, referring to more conflicting relationships.

People claim that there is a need to develop relationships for healthy living in communities, which is revealed in the data that follows:

> *You have to go out, meet people, talk, make your brain available to other people, go to places, I like to do that* (Babaçu 14 - Group B).

> *Of course, you are alone without having contact with someone, I think it makes the person upset, ah! begins to go into depression* (Baru 17 - Group C).

The absence of relationships in society is identified as a potentially sickening condition. However, the social relationship does not occur without consequences in people's lives. Both **therapeutic** and **sick effects** arising from the interaction with the **Other** can be evidenced.

> *There are certain types of people that make us sick, because my own marriage was driving me crazy (Baru 17 - Group C).*

> *So, I'm in favor of the following, no matter how much you are a mother, husband, brother, son, whatever, if you get intoxicated, I think that for you to be in harmony in community you have to be in harmony first. You will not be able to help anyone if you feel bad* (Jenipapo 23 - Group D).

The meanings attributed to relationships and interaction with the Other are developed in the Mind, leading people to search for **harmonious social relationships** or to end the **sick relationships.**

> *Tribulation, I think it brings various types of diseases, living in a tribulated life is about fights, indifference, treating people with indifference* (Caju 07 - Group B).

It is revealed that **peace** is sought in relationships and is a symbol of harmonious relationships, influencing people's action to build relationships that bring this feeling, which constitutes self-care and improving the quality of life.

> *So, if you have peace, you have everything to live well, you have to be healed, get well from the soul of the spirit* (Cambarás 16 - Group B).

> *It interferes directly, because when you are well with your family, you have peace, your environment that you live with when you rest, you feel good, when you can say something that you are feeling, without being worried about what people will think, you must be direct, you have to be careful with words, I don't know, you only contribute because you feel peace, you feel loved* (Araça 23 - Group D).

Constituting the **needs of everyday life**, we have already presented the results that relate to **self-care** and **social relationships**. In the third subcategory, explained below, the interaction of people with the environment in which they live is analyzed.

Third Subcategory: Relationships with the place of everyday life - Environment

According to data analysis, the third subcategory is conceptualized by the **relationships** built between people and the **location** where daily life is experienced. People's daily lives take place in a location where life happens, where people interact both with themselves, with others and the **environment**.

In the interaction of people with the place where they live, there are symbols built throughout life that resulted in a relationship of affection, influencing the quality of life and self-care. When this relationship is based on **affection for the place of residence**, there is an improvement in people's quality of life. When the feeling in relation to the space where one lives is **disaffected**, it can contribute to **illness.**

> *From the micro of the house to the city, people, what kind of work they do, where they walk in some way affects their health, so, from the environment that the person has in the physical house, this house is well ventilated house enters fresh air in sunlight. [...] if she lives in a very busy city if her lifestyle is tense if the city she lives in, if the air is pure or polluted, [...] the whole context that the person is in affects health* (Heliconia 19 - Group D).

> [...] *I think depression is a matter of the environment in which we live, of the environment in which we are* (Tambaqui 18– Group C).

The data demonstrate that in everyday life there can be coexistence of both **affection** and **disaffection relationships**

between the participants and their **places of residence**. Housing in the city is symbolic and signified as potentially sickening. The symbolic environment of life in the countryside was called a potentially favorable environment for care, due to the reported therapeutic effects of this experience. The contact with nature, the interaction with more bucolic environments, is portrayed by people as healthier environments.

> *I don't like Coxim, declared. In my farm I look at the horizon early, I don't run the risk of being shot in the face [...] And in the background I look full of forest cheio de mata, it seems like paradise, spring time ipe purple ipê roxo, yellow, why do I need another therapy than that? I talk to chicken, my sheep even had a name, my cow has a name, I call it by name, at night I look at the moon at will à vontade* (Aguapé 05 - Group B).

> *Life in the countryside is better, I was born and raised in the countryside, I miss the countryside if I could work I would rather live in the countryside, I don't like the city, it's too busy and has a lot of noise* (Seriguela 11 - Group B).

Coexistence in more rural environments, close to vegetation and elements of nature, is considered a symbol of health, contributing to the quality of life of people in these regions.

The **sanitary issues** that surround the external environment of the residence influence both the **internal environment** of the house and the relations with the place of residence. The absence of **sanitary conditions**, such as basic sanitation at home and other factors external to housing, is also a condition that minimizes the quality of life in everyday life, including environmental pollution and the habits of burning in the heat.

> *As there are sectors that do not go well, I think that, like basic sanitation, something that does not go well, in the care of the neighborhoods' cleaning land, things influence what ends up striking health* (Pequi 15 - Group C).

In addition to the place of residence, they also reflect the relationship of people with the location, **hygiene habits and the organization of the environment.** Care for the **internal environment** is meant as a constituent of self-care, as evidenced in the data that follow.

> *There is hygiene at home, what you are going to eat, it has to be very clean, health starts there is part of health; the house can be knocked down like mine, being very clean* (Babaçu 14 - Group B).

> *If everything is very well balanced, the place where you are, cleaning, cleansing, aroma, you are healthier, you are healthier at that moment at least. [...] If the environment is messy, it gets in the way. [...] the yard is full of bricks, it is full of tiles, because it is still under construction, right? [...] and that unbalances me. It makes me nervous, stressed and it's not healthy to see my yard full of things, I could be with the grass all cute, full of flowers and trees. This would make me much better, much healthier* (Jenipapo 23 - Group D).

The care relationship with the residence environment interacts with the care relationships of the Others that make up the community. The lack of **hygiene** and care for the home harms the quality of life in the **living environment**, enabling the presence of vectors such as rodents.

> *The neighbor's yard, right, which is a pain, as you can see, here at home and here at my brother-in-law's house is infested with mice because the yard here is very dirty, without good conditions [...] then I have to take care of children, because rat is dangerous. Ah, everyone knows that mice cause disease* (Flor de Maracujá 02 - Group A).

> Ah, especially in our region, here people set fire to the bush, then there is a smoke and ends up with us *(Baru 17 - Group C).*

The relationship of people with the space where they live dialogues with the actions and habits of Others about living in society. It is noticed that the subcategories are interrelated and dialogue with each other, as they are elements of actions in search of self-care, in the interaction of people, both with each other and with themselves, in a reflection and thoughts that lead to ways of living and interact in society.

The health needs of everyday life are generated by the relationships that exist between the subcategories that have been presented. Next, a discussion of the theoretical findings will be held, dialoguing with the literature.

DISCUSSION

It is emphasized in this discussion that, in the analysis of the process that takes place in theorization, the health needs of everyday life are not configured as demands reported in the search for care in PHC. Symbolically, for the study participants, health services exist for the care and assistance of situations that surround illness.

However, the unmet needs are present in people's daily lives, and are often welcomed by churches, social communities, pharmacists, while they could be seen and cared for by health

services, in an attempt to promote quality of life and achieve integrality.[3-5]

As shown by the results of health needs studies of market women, comprehensive care cannot be achieved by the sole action of health professionals, and there is an urgent need for coordination between different sectors of society.[3]

The analyzed data and constructed diagrams allow us to understand that the health needs are greater than the demand that reaches the ears of health professionals. Corroborating, studies conducted with individuals with tuberculosis demonstrate that health needs go beyond the physical dimension, being associated with the dynamics of life in society and the experiences lived in health services.[9]

Studies show that adequate food, decent housing with basic sanitation and living conditions that allow access to leisure are components of health needs, which is corroborated by the results of this research.[9]

Adequate food, the practice of physical activities and the culture of peace are some of the nuances to be considered for health promotion to occur, articulating other sectors for poverty reduction and with guaranteed access to healthy living habits.[10]

In this perspective, the data demonstrated that the financial condition affects access or not to minimum living conditions in capitalist society, which is a concern of the participants regarding the possibility of achieving maintenance for self-care.

Studies have found that the implementation of integrative and complementary practices in SUS, such as the bodily practices of traditional Chinese medicine, contributes to improving people's quality of life, influencing self-care and contributing to health promotion in PHC.[11,12] However, these practices have not yet been implemented in the reality of PHC in the municipality studied.

Thus, even though laws have been published that aim to achieve health promotion in SUS, in the context studied, data reveal that the needs of people in daily life are not important to be attended to or cared for by health professionals, remaining invisible.[5]

People have deficiencies that lead to consequences on their quality of life and that are not seen by health professionals, are not part of the demand and are not discovered, which compromises the integrality of care and the implementation of practices aimed at health promotion.[5,10,13]

In a study conducted with adolescents, it was evidenced that the vulnerabilities of this population group are not prioritized in PHC, with services organized for the prevention and treatment of diseases.[13]

The National Health Promotion Policy (*Política Nacional de Promoção da Saúde*- PNPS) proposes that the planning of care actions is based on a concept of health that goes beyond the absence of the biological aspects of illness, favoring choices of self-care in daily life that increase the quality of life.[10]

However, the PNPS also reiterates that in order to achieve integrality in health care, it is necessary to articulate with other policies and regulations, involving other sectors of society.[4,5,10]

In this perspective, the urgency of more public investments in PHC is reiterated so that people's health needs are taken care of, with quality and in all its complexity.[14]

It is understood, in an interactionist perspective, that people do not act mechanically in society, their actions being the result of symbolic interactions based on their relational experiences in the daily lives of health services.[4,5]

Thus, in order to achieve the care of the health needs experienced in daily life, it is necessary to organize the PHC to assist non-demanded problems, articulating multiprofessional teams, the community and other social sectors in search of integrality, going beyond the walls of the health units.[14]

CONCLUSIONS

It was found that the daily needs of people's lives remain invisible in the eyes of professionals. When they distance themselves from biological demands, they are not part of what the user means as a possible demand for the health service. In this way, they remain neglected to the empirical care of the community.

In the interaction with the user, PHC could support both self-care and the relationships developed in the community, aiming at improving the quality of life of people in the society in which they are inserted.

Sometimes, the biological demands of illness can result from needs that are part of daily life and are being neglected, as they cannot be measured or visualized, since they come from the daily lives of people and their relationships in this area. Thus, it is necessary to reflect on the experiences that are being lived in health services, as these have reinforced the symbol that health services in PHC are organized for the care of sick people.

In this perspective, this study can contribute to the planning of Nursing care that are related to the health needs of everyday life, to the problems not demanded, contributing to the development of health promotion actions that increase the quality of life of families. The findings of this research corroborate the premise that the bond and qualified listening are essential for the knowledge, by nurses, of the health needs that are related to self-care, social relationships and the user's environment.

The objectives proposed for carrying out the study were achieved, since it was possible to understand the properties that underlie the meaning of health needs specific to the daily lives of PHC users in the municipality studied.

It is stated as a limitation of this research the impossibility of deepening the role of the nurse in the care of health needs, requiring research that relate the needs of daily life to the care of nurses in PHC.

The results unveiled show the need for further research to encourage reflection on organizational practices and professional attitudes aimed at caring for the health needs of the users' daily lives, in various care contexts, both in PHC and in secondary and tertiary health care services in the scope of SUS, as in private care services.

Thus, the results of this theoretical construction are in dialogue with the literature and demonstrate that it is necessary to face the challenge of fully assisting the PHC user in their health needs, in order to advance in the practical application of SUS ordinances and resolutions, promoting health and not disease, quality of life throughout existence and not only in specific moments of illness, promoting new ways of reflecting the praxis and acting for the care of the user.

REFERENCES

1. Camargo Júnior KR. On health needs: the concept labyrinth. Cad Saúde Pública. 2018[cited 2019 Jan 22];34(6):e00113717. Available from: http://dx.doi.org/10.1590/0102-311x00113717
2. Cassettari SSR, Mello ALSF. Demand and type of care provided in emergency services in the city of Florianópolis, Brazil. Texto Contexto Enferm. 2017[cited 2019 July 27];26(1):e3400015. Available from: http://dx.doi.org/10.1590/0104-07072017003400015
3. Magalhães AHR, Parente JRF, Silva MAM, Pereira IH, Vasconcelos MIO, Guimarães RX. Health needs of street market saleswomen: access, connection and welcoming as integral practices. Rev Gaúcha Enferm. 2016[cited 2019 Feb 12];37(n.spe):e2016-0026. Available from: http://dx.doi.org/10.1590/19831447.2016.esp.2016-0026. 3
4. Palhoni ARG, Penna CMM. Health care in the constitution of health needs for users of the family health strategy. Ciênc Cuid Saúde. 2017[cited 2018 June 30];16(4):e40371 Available from: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude article/view/ 40371/21985
5. Farão EMD, Penna CMM. The (in) visibility of health needs. Ciênc Cuid Saúde. 2017[cited 2018 June. 30];16(4):e45180. Available from: http://dx.doi.org/10.4025/cienccuidsaude.v18i2.45180
6. Blumer H. Symbolic interactionism: perspective and method. Englewood Cliffs, NJ: Prentice-Hall; 1969. 208 p.
7. Carvalho VD, Borges LO, Rêgo DP. Interacionismo simbólico: origens, pressupostos e contribuições aos estudos em psicologia social. Psicol Ciênc Prof. 2010[cited 2019 Feb 15];30(1):146-61. Available from: http://dx.doi.org/10.1590/S1414-98932010000100011
8. Strauss A, Corbin J. Pesquisa qualitativa: técnicas e procedimentos para o desenvolvimento da teoria fundamentada. 2a ed. Porto Alegre: Artmed; 2008.
9. Hino P, Bertolozzi MR, Takahashi RF, Egry EY. Necessidades em saúde segundo percepções de pessoas com tuberculose pulmonar. Rev Esc Enferm USP. 2012[cited 22 Jan 2018];46(6):1438-45. Available from: http://www.scielo.br/pdf/reeusp/v46n6/22.pdf
10. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde: PNPS: revisão da Portaria MS/GM nº 687, de 30 de março de 2006. Brasília: MS; 2015.
11. Santos MS, Amarello MM, Vigeta SMG, Horta ALM, Tanaka LH, Souza KMJ. Práticas integrativas e complementares: avanços e desafios para a promoção da saúde de idosos. REME – Rev Min Enferm. 2018[cited 2019 Aug 19];22:e-1125. Available from: https://doi.org/10.5935/1415-2762.20180048
12. Dacal MPO, Silva IS. Impactos das práticas integrativas e complementares na saúde de pacientes crônicos. Saúde Debate. 2018[cited 2019 Aug 03];42(118):724-35. Available from: http://dx.doi.org/10.1590/0103-1104201811815
13. Luz RT, Coelho EAC, Teixeira MA, Barros AR, Carvalho MFAA, Almeida MS. Estilo de vida e a interface com demandas de saúde de adolescentes. REME – Rev Min Enferm. 2018[cited 2019 Apr 15];22:e-1097. Available from: https://doi.org/10.5935/1415-2762.20180027
14. Giovanella L. De Alma-Ata a Astana. Atenção primária à saúde e sistemas universais de saúde: compromisso indissociável e direito humano fundamental. Cad Saúde Pública. 2019[cited 2019 Aug 19];35(3):e-00012219. Available from: https://doi.org/10.1590/0102-311X00012219