The Health Profile of Basic Care Network Users According to the e-Sus Individual Registry

Perfil de Saúde dos Usuários da Rede de Atenção Básica Baseado no Cadastro Individual e-Sus

Perfil de Salud de los Usuarios de la Red de Atención Básica Basada en el Cadastro Individual e-Sus

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ABSTRACT

Objective: The study's purpose has been to assess the health profile, based on the individual registry named e-SUS *(Sistema Único de Saúde* [Unified Health System]), in regards to the users of basic health care services in Ijuí city, *Rio Grande do Sul* State. **Methods:** It is a cross-sectional study with a sample of 400 registered users in 15 Family Health Strategies, within the age group from 20 to 59 years old and according to the e-SUS individual registry. **Results:** There was a predominance of wage earners with a work permit and low education level. Users with low schooling were five times more likely to develop diabetes mellitus (p=0.01), whereas high education users were hospitalized more frequently (p=0.03). It was observed an association between participating in a community group and the female gender (p=0.013), having high education level and private health insurance plan (p=0.001). **Conclusion:** The profile of the users shows a direct relationship between low level of schooling and chronic noncommunicable diseases and inversion of hospitalizations.

Descriptors: Population Characteristics, Family Health Strategy, Primary Health Care, Unified Health System.

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RESUMO

Objetivo: Verificar o perfil de saúde, baseado no cadastro individual e-SUS, de usuários dos serviços de atenção básica da cidade de Ijuí/RS. **Métodos:** Estudo transversal, com amostra de 400 usuários cadastrados em 15 Estratégias de Saúde da Família, na faixa etária de 20 a 59 anos, baseado no cadastro individual e-SUS. **Resultados:** Verificou-se predomínio de assalariado com carteira de trabalho, baixa escolaridade. Os usuários com escolaridade baixa tiveram cinco vezes mais chance de desenvolver diabetes mellitus (DM) (p=0,01), com escolaridade alta internaram com maior frequência (p=0,03). Observou associação entre participar de grupo comunitário e o sexo feminino (p=0,013) e apresentar alta escolaridade e possuir plano de saúde privado (p=0,001). **Conclusão:** O perfil dos usuários mostra relação direta da baixa escolaridade com doenças crônicas não transmissíveis e inversa as internações.
Descritores: Características da População, Estratégia Saúde da Família, Atenção Primária à Saúde, Sistema Único de Saúde.

RESUMEN

Objetivo: Verificar el perfil de salud, basado en el registro individual e-SUS, de usuarios de los servicios de atención básica de la ciudad de Ijuí/RS. **Metodos:** Estudio transversal, con muestra de 400 usuarios registrados en 15 Estrategias de Salud de la Familia, en el grupo de edad de 20 a 59 años, basado en el registro individual e-SUS. **Resultados:** Se verificó predominio de asalariado con carnet de trabajo, baja escolaridad. Los usuarios con escolaridad baja tuvieron cinco veces más posibilidades de desarrollar diabetes mellitus (DM) (p = 0,01), con escolaridad alta internaron con mayor frecuencia (p = 0,03). Se observó asociación entre participar en el grupo comunitario y el sexo femenino (p = 0,013) y presentar alta escolaridad y tener un plan de salud privado (p = 0,001). **Conclusión:** El perfil de los usuarios muestra relación directa de la baja escolaridad con enfermedades crónicas no transmisibles e inversa las internaciones.
Descriptores: Características de la Población, Estrategia Salud de la Familia, Atención Primaria a la Salud, Sistema Único de Salud.

INTRODUCTION

The change in the epidemiological health profile in the country comes with the predominance of Chronic Noncommunicable Diseases (CNCD), a consequence of urbanization, changes in lifestyles and globalization.[1] In Brazil and other Latin American countries, studies show that there has been a change in the health profile in the last decades, with changes in mortality and morbidity and mortality in the population, a phenomenon known as the epidemiological transition, characterized by the substitution of the main causes of death, which occurred previously due to infectious and parasitic diseases, a position that was then occupied by so-called CNCD, especially those related to the circulatory system, since they are considered the main responsible for the largest contingent of deaths worldwide.[1,2]

In general, the majority of the population has predisposing factors to develop diseases, especially those related to lifestyle, among which is the practice of inadequate food, composed of foods with a high caloric content and low nutritional value, thus contributing to the occurrence of risk factors and, consequently, for the development of numerous diseases.[3] Furthermore, the hectic pace of life adopted by contemporary society, as well as environmental, demographic and socioeconomic factors are associated with health conditions.[4,5]

In Brazil, the Family Health Strategy (FHS) is the assistance model of primary health care, primarily for populations with greater biological and socioeconomic risk. The multiprofessional teams in the Basic Health Units are responsible, among other attributions, for the prevention, control, and diagnosis of the most frequent diseases. The monitoring percentage is one of the indicators for monitoring and evaluating this strategy.[6] In order to know this percentage, as well as other indicators, the individual user registry was developed, which is a standard questionnaire that was organized by the Ministry of Health to be executed by the health agents of each Family Health Strategy, consisting of questions that respond to personal characteristics, sociodemographic data and general health issues of users in the territory of the teams.[6] According to the Primary Care Department of the Ministry of Health, the Ordinance No. 1,412, July 10th, 2013, has made it mandatory to fill in the online data system named e-*SUS* (*Sistema Único de Saúde* [Unified Health System]), and this allowed a systematic analysis of the results.[6]

Information about the health profile of individuals is of paramount importance for the optimization of health services, seeking to reduce expenses and excellence of services provided to the population. Moreover, it aims to help sensitize health professionals and beneficiaries about the importance of knowing how this population is in relation to their health. So, there is a perspective of implementation of practices that contemplate actions of promotion, prevention, protection, and care for this target population, thus influencing in a positive way the control of possible risk factors and appropriate treatment for people who are sick. It was observed the precariousness of studies in the bibliography that identify the health situation addressing the age group from 20 to 59 years old, so the approach of this theme will serve as an indicator of the health profile of the population bellonging to the basic health care network.

Given the aforementioned, this study aimed to verify the health profile of users assisted by the basic health care network belonging to the *Ijuí* city, *Rio Grande do Sul* State, within the age group from 20 to 59 years old and according to the e-*SUS* individual registry.

METHODS

It is a documentary, cross-sectional, analytical and quantitative study. The present study included users bellonging to the basic care network from the *Ijuí* city, *Rio Grande do Sul* State, in the adult age ranging from 20 to 59 years old. The data were collected from the information collected from the 15 FHSs in the municipality, all of which have the data of registered users in a single database, the

e-*SUS*. Sampling was performed, with a 5% error and 95% confidence level, obtaining a sample of 400 people, which were proportionally stratified in all Family Health Strategies, in proportion to the size of the population in each one. The e-*SUS* is filled by the community health agents, the data were collected in random order.

The e-*SUS* is a strategy of the Primary Care Department to restructure the information of Basic Care at national level.[6] This action is in line with the more general proposal for restructuring the Health Information Systems of the Ministry of Health, understanding that the qualification of information management is fundamental to increase the quality of care to the population.[6] There were included in this study the registries of individuals within the age group from 20 to 59 years old who are users of the basic care network, registered in the Family Health Strategies from the *Ijuí* city, *Rio Grande do Sul* State.

In the individual register, the information was collected that includes user identification data with sociodemographic information. The following questions were asked to the users: gender, race, nationality, birthplace, marital status, attending school, attending or have attended higher education programs, situation in the labor market, "Do you visit a healer?", "Do you attend a community group?", "Do you have a private health insurance plan?", "Do you want to provide sexual orientation/gender identity?", "Do you have any disability?".

The general health conditions/situations were composed of the following questions: "Are you pregnant?", "What do you consider about your weight?", "Are you a smoker?", "Are you dependent of alcohol or do you abuse it?", "Are you dependent of drugs or do you abuse it?", "Do you have high blood pressure?", "Do you have diabetes?", "Have you ever had a stroke?", "Have you ever had an infarction?", "Do you have a kidney disease or have you had it?", "Do you have respiratory disease?", "Do you have leprosy?", "Do you have tuberculosis?", "Have you had cancer or have it now?", "Have you been or are you being treated by a psychiatrist, or even was hospitalized due to a mental health issue?", "Are you bedridden, domiciled?","Do you make use of medicinal plants?","Do you use other integrative and complementary practices?".

The other questions were about the street situation: "Are you living in the street?", "Do you receive any benefit?", "Do you have family support?", "Have you been looked after by another institution?", "Do you visit any family member?", "How often do you eat per day?", "What is the food source?", "Do you have access to personal hygiene?".

Schooling was stratified into low and high. In low schooling was included, kindergarten, pre-school, literacy class, elementary school from 1st to 4th year, and from 5th to 8th year, special elementary school, *Educação de Jovens e Adultos (EJA)* [Youth and Adult Education] from 1st to 4th year, and from 5th to 8th year, literacy for adults (*mobral*, etc.) or no literacy. In high schooling was included high

school (scientific, technical) special high school, *EJA* high school, specializations, masters and doctorates.

After data collection, they were then tabulated and analyzed through the Statistical Package for Social Sciences - SPSS (version 22.0, Chicago, IL, USA). The descriptive analysis was performed with mean and frequency. For the association analysis, the Chi-square test was used. The significance level was 0.05 and the Confidence Interval (CI) was 95%.

The study was designed according to the Directives and Norms Regulating Research Involving Human Beings according to the Resolution of the National Health Council No. 466/2012 and was submitted and approved by the Ethics Committee from the *Universidade Regional do Noroeste do Estado do Rio Grande do Sul (UNIJUI)* No. 1,564,051/2016, and the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 55076016.2.0000.5350.

RESULTS AND DISCUSSION

This study has analyzed 400 registries of users enrolled in the primary care network. There was a predominance of females, within the age group from 50 to 59 years old, white race (skin color), and married. Moreover, there was a predominance of wage earners with a work permit, low educational level, according to data presented in **Table 1**.

Table 1- Sociodemographic characterization of Family Health Strategy users registered in the e-SUS. *Ijuí* city, *Rio Grande do Sul* State, 2015.

Variable	n(%)
Gender	
F/M	223(55.8)/177(44.2)
Age	
50-59	113(28.2)
40-49	51(12.7)
30-39	70(17.5)
20-29	47(11.7)
Race (skin color)	
White	389(97.3)
Black/brown/yellow	02(0.5)/08(2.0)/01(0.3)
Marital status	
Married/living with a partner	277(69.3)/30(7.5)
Single	74(18.5)
Divorced/widowed	09(2.3)/10(2.5)
Sexual orientation	
Heterosexual	269(67.3)
Not informed	131(32.2)
Situation in the labor market	
Wage earner with a work permit/ without a work permit	106(26.5)/25(6.3)
Other	103(25.8)
Retired/pensioner	57(14.3)
Not working	50(12.7)
Self-employed with social security/ without social security	23(5.8)/19(4.8)
Unemployed	12(3.0)
Employer	05(1.3)

Educational level	
Low	281(70.3)
High	179(29.7)

Answers concerning to n: number of individuals; %: percentage of individuals, M: male. F: female.

Table 2 shows self-reported answers about the users' comorbidities. Among the patients with stroke, the majority were male (p=0.05). Users with low schooling were five times more likely to develop Diabetes Mellitus (DM) (p=0.01) and users with high schooling had more frequent hospitalization (p=0.03).

Table 2- Disease and comorbidities of Family Health Strategy users registered in the e-SUS. *Ijuí* city, *Rio Grande do Sul* State, 2015.

Variable	All	Gender				Schooling			
	n (%)	M n(%)	F n(%)	OR (CI)	p-value	Low n(%)	High n(%)	OR (CI)	p-value
Smoker	58 (14.5)	30 (51.7)	28 (48.3)	0.69(0.39-1.22)	0.20	44 (75.8)	14 (24.2)	1.39(0.73-2.65)	0.31
Alcoholic person	05 (1.3)	05 (100)	-	1.03(1.00-1.06)	0.11	03 (60)	2 (40)	0.63(0.10-3.83)	0.61
Drugs	02 (0.5)	02 (100)	-	1.01(0.99-1.03)	0.11	01 (50)	01 (50)	0.42(0.03-6.79)	0.53
Adequate weight	314 (78.5)	154 (49.1)	160 (50.9)	1.23(1.02-2.33)	0.11	220 (70)	94 (30)	0.82(0.46-1.48)	0.51
SAH	61 (15.2)	26 (42.7)	35 (57.3)	1.07(0.62-1.85)	0.81	49 (80.3)	12 (19.7)	1.88(0.96-3.69)	0.061
DM	25 (6.3)	09 (36)	16 (64)	1.72(0.73-4.09)	0.21	23 (92)	02 (8.0)	5.21(1.21-22.49)	0.01*
Stroke	03 (0.8)	03 (100)	-	1.01(0.99-1.04)	0.05*	02 (66.6)	1 (33.4)	0.84(0.07-9.42)	0.89
Infarction	02 (0.5)	01 (50)	01 (50)	0.78(0.49-12.64)	0.86	02 (100)	-	0.99(0.98-1.00)	0.36
Cardiac disease	08 (2.0)	04 (50)	04 (50)	-	0.54	05 (62.5)	01 (37.5)	-	0.72
Kidney disease	17 (4.2)	04 (24.6)	13 (76.4)	-	0.26	10 (58.8)	07 (41.2)	-	0.49
Respiratory disease	10 (2.5)	05 (50)	05 (50)	-	0.64	06 (60)	04 (40)	-	0.15
Cancer	11 (2.8)	08 (72.7)	03 (18.3)	1.39(0.4-4.82)	0.61	07 (63.6)	04 (36.4)	0.73(0.21-2.56)	0.63
Disability	23 (5.7)	10 (43.7)	13 (56.3)	1.02(0.44-2.39)	0.57	14 (60.8)	09 (39.2)	0.64(0.27-1.52)	0.81
Mental disease	14 (3.5)	09 (64.3)	05 (35.7)	0.78(0.27-2.26)	0.645	11 (78.5)	03 (21.5)	1.57(0.43-5.75)	0.49
Hospitalization over the last 12 months?	16 (3.8)	03 (14.4)	13 (86.6)	-	0.16	06 (40)	09 (60)	1.55(1.12-1.99)	0.03*

Answers concerning the yes reply. SAH: systemic arterial hypertension. DM: diabetes mellitus. M: male. F: female. n: number of individuals; %: percentage of individuals, OR(CI): odds ratio, CI: (confidence interval), p≤0.05 statistically significant.

The self-reported answers in regards to both general and health characteristics are shown in Table 3. It was observed an association between participating in a community group and the female gender (p=0.013), having high education level and private health insurance plan (p=0.001).

Some questions present in the instrument used here were not answered affirmatively by any interviewee, among whom we cite: being pregnant, bearing leprosy, having tuberculosis, being bedridden or domiciled. It was observed that the question about users living in the street was not answered in all the analyzed instruments.

Table 3- Both general and health characteristics of Family Health Strategy users registered in the e-SUS. *Ijuí* city, *Rio Grande do Sul* State, 2015.

Variable	All	Gender				Schooling			
	n (%)	M n(%)	F n(%)	OR (IC)	p-value	Low n(%)	High n(%)	OR (IC)	p-value
Do you visit a healer?	13 (3.2)	09 (69.2)	04 (30.8)	0.48 (0.15-1.49)	0.195	09 (69.2)	04 (30.8)	0.95 (0.29-3.15)	0.935
Do you attend a community group?	34 (8.5)	12 (35.2)	22 (64.8)	1.99 (2.12-4.29)	0.013*	25 (73.5)	09 (26.5)	1.91 (0.54-2.64)	0.662
Do you have a private health insurance plan?	15 (3.2)	06 (40)	09 (60)	1.18 (0.41-3.39)	0.75	04 (26.7)	11 (73.3)	0.14 (0.04-0.46)	0.001*
Do you make use of medicinal plants?	60 (15)	12 (20.0)	48 (80.0)	2.99 (1.59-5.64)	0.001*	40 (66.6)	20 (33.4)	0.82 (0.46-1.48)	0.51

Answers concerning the yes reply. n: number of individuals; %: percentage of individuals, OR(CI): odds ratio, CI: (confidence interval), p≤0.05 statistically significant.

The health profile of basic care services users from the *Ijuí* city were analyzed through 400 individual *e-SUS* registries. The main data of this research show a predominance of wage earners with a work permit and low educational level. Considering the patients who had a stroke, the majority were male. Users with low schooling were five times more likely to develop diabetes mellitus, and users with high schooling had more frequent hospitalization. It was observed an association between participating in a community group and the female gender, having high education level and private health insurance plan.

The data of this research demonstrate that 15.2% of the users declared to present SAH. This disease is among the world's public health problems, with increasing prevalence.[7] In the sample, there was a higher prevalence among women and 80.3% had a low educational level g, data found by Godoy (2010) as well.[9] In Brazil, the "*Vigitel Brasil*" study (Surveillance of Risk Factors and Protection for Chronic Diseases by Telephone Inquiry) verified that, in 2013, 24.1% had a medical diagnosis of SAH in the 27 Brazilian capitals, being 26.3% between women and 21.5% among men, with the frequency of diagnosis increasing with increasing age,[8] these data refer to the general population, differing from the present survey which included age up to 59 years old.

Herein, it was found that 14.5% of the participants are active smokers and of these, the male prevails (51.7%), 75.8% had studied up to eight years. Smoking is associated with cardiovascular diseases, cancer, chronic obstructive pulmonary diseases, pneumonia and asthma, ocular problems, among others.[11] Some studies also show that the average number of active smokers in the Brazilian adult population was 16.1%, with a predominance of males (20.5%) and higher among those with up to eight years of education.[10-2]

Among the analyzed charts, three cases of stroke were reported, all of them male, as pointed out by Silva and Lin (2016).[13] According to Paes (2016),[11] the incidence of stroke in young adults is increasing, especially at the expense of smoking. It is estimated that the percentage of young adults reaches 5 to 10% of the total number of individuals with stroke and its incidence in this age group ranges from 7 to 15 cases per 100,000 individuals/year.

Another disease that stood out among the users was DM, an important global health problem, with an increasing incidence and high morbidity and mortality, resulting in a significant loss of life quality.[9] DM affected 6.3% of users, more frequently among women and with less than eight years of schooling. It was verified that users with low schooling are five times more likely to have this disease. This data was also verified by a study in which 4.9% reported DM, with a predominance of females and incomplete primary education,[9] showing a relationship between education, low economic class and the presence of comorbidities, being this population that has greater financing by the the SUS (*Sistema Único de Saúde*) [Brazilian Unified Health System].[12]

The CNCD also affect the labor market, as the affected individuals end up losing workforce, impacting on the Brazilian productive sector. Estimates for Brazil that this is the 4th cause of work leave, in the period from 2006 to 2015, representing a loss of US $ 4.18 billion. Losses related to disabilities, direct material costs to patients, family impoverishment, and the financial impact on the public health system are highlighted as well.[14]

The low level of schooling presented by most e-SUS registries assessed in this study may limit access to information, possibly compromising reading, writing and speech skills, and may impact on the understanding of disease risk factors and treatment. It should be emphasized that low educational level, frequent in the population served by the public health service, should be a factor considered by professionals in the construction of health education activities developed in primary care.

It was verified that users with chronic non-communicable diseases (15%), use complementary therapies with medicinal plants, and 60% of these had a low educational level. The study by Lima *et al.* (2014)[15] reinforces these results and brings the predominance among illiterates (36%); furthermore, many users have traditional knowledge about plants and are unaware of their toxicity. Still on this topic, it should be highlighted the risk of using medicinal plants without the guidance of qualified health professional and administered associated with medications, which might increase the risk of drug interaction.[16,17] Therefore, the importance of the community to be oriented regarding the way of using and preparing them, contributing to a complementary therapeutics safe for the *SUS* users.

For the active participation of the community in the team's actions, it becomes necessary to empower the users in the health control individually and collectively. Control that goes through the possibility of identifying the yearnings, the basic human needs, as well as of intervening in the local environment.[18,19] Herein, 8.5% attended community groups, with a predominance of women, a fact that shows us that the female sex is more concerned about their health.

This study is important since it brings results of the individual cadastre of a municipality of Brazil. It is the reflection of the policy that is currently being advocated by the federal government with the FHS, with an important role played by community health agents. Nevertheless, the study has limitations in its results including the fragility of data recorded in the individual register, on which this research was based. The register is composed of some self-referenced questions, and users may have incorrectly answered or omitted information, allowing biases regarding the issues that fit in the general health conditions/situations. Some self-reported responses may have limitations to serve as a diagnosis. Regarding the user's weight, a self-reported variable, without evaluation by validated diagnostic methods, the answers being conditioned to an individual evaluation of the users, which can be overestimated or underestimated. For Cardoso *et al.* (2013),[18] the weight tends to be underestimated frequently by women. Therefore, can this diagnosis be considered real vis-à-vis the users' health? To what extent is the questionnaire effective as it is being formulated and implemented? What impact does it have on the changes in the health policies of the country and the FHS, since the implementation is mandatory by community health agents. Another worrying issue concerns questions not met by collectors, including street users, pregnant women, bedridden and domiciled, who can demonstrate misunderstandings in filling out such forms and the need for training and validation of this material.

Concisely, the application validity of this form is questioned, also its current form, due to the lack of training to applying it, having either poor or unfilled questions, then showing that some data might not correspond to reality.

CONCLUSIONS

Through this research, it was possible to verify the health

profile of *SUS* users within the age group from 20 to 59 years old, who were located in *Ijuí* city, *Rio Grande do Sul* State. The main findings of this profile show the predominance of wage earners with a work permit, low education level. Users with low schooling were five times more likely to develop diabetes mellitus, and users with high schooling had more frequent hospitalization. It was also found an association between participating in a community group and the female gender, having high education level and private health insurance plan.

Hence, this study is important to report that individuals presented a significant number of chronic non-communicable diseases, which may represent a poor prognosis for health with advancing age if health education actions are not performed with this population.

Bearing in mind the aforesaid, the optimization and awareness of health services will be of vital importance, also the monitoring of risk factors and the prevalence of diseases related to them is paramount for the definition of health policies aimed at the prevention of these diseases, having as main focus the chronic non-communicable diseases present in the health profile of this age group.

REFERENCES

1. Malta DC, Cezário AC, Moura L, Neto OLM, Junior JBS. A construção da vigilância e prevenção das doenças crônicas não transmissíveis no contexto do Sistema Único de Saúde. Epidemiol. Serv. Saúde 2006; 15(1): 47-65. Available at: http://scielo.iec.gov.br/pdf/ess/v15n3/v15n3a06.pdf
2. Castro RCL, Knauth DR, Harzheim E, Hauser L, Duncan BB. Avaliação da qualidade da atenção primária pelos profissionais de saúde: comparação entre diferentes tipos de serviços. Cad. Saúde Pública 2012; 28(9): 1772-84. Available at: https://www.scielosp.org/scielo.php?pid=S0102-311X2012000900015&script=sci_arttext&tlng=e
3. Souza LP et al. Eventos adversos: instrumento de avaliação do desempenho em centro cirúrgico de um hospital universitário. Rev. Enferm. Uerj, 2011; 19(1): 127-33. Available at: http://www.facenf.uerj.br/v19n1/v19n1a21.pdf
4. Brink CLVD et al. Self-Reported Disability and Its Association with Performance-Based Limitation in Elderly Men: A Comparison of Three European Countries. J. Am. Geriatr. Soc. 2003; 51(6): 782-8. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2389.2003.51258.x
5. Pinto SL, Silva RSR, Priore SE, Assis AMO, Pinto EJ. Prevalência de pré-hipertensão e de hipertensão arterial e avaliação de fatores associados em crianças e adolescentes de escolas públicas de Salvador, Bahia, Brasil. Cad. Saúde Pública 2011; 27(6): 1065-75. Available at: https://www.scielosp.org/article/csp/2011.v27n6/1065-1075/
6. Brasil. Rede Interagencial de Informação para a Saúde. Indicadores básicos para a saúde no Brasil [Internet]. Brasília: Organização da Saúde. 2. Ed. Brasília: Organização Pan-Americana da Saúde, 2008. Available at: http://tabnet.datasus.gov.br/tabdata/livroidb/2ed/indicadores.pdf
7. Selem SSC, Castro MA, César CLG, Marchioni DML, Fisberg RM. Validade da hipertensão autorreferida associa-se inversamente com escolaridade em brasileiros. Arq. Bras. Cardiol. 2013, 100(1): 52-9. Available at: http://www.scielo.br/pdf/abc/v100n1/aop11612.pdf
8. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. VIGITEL Brasil 2012 - Vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico. Brasília: Ministério da saúde, 2014. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/vigitel_brasil_2014.pdf
9. Godoy I. Prevalência de tabagismo no Brasil: medidas adicionais para o controle da doença devem ser priorizadas no Ano do Pulmão. J. Bras. Pneumol. 2010; 36(1): 4-5. Available at: http://www.scielo.br/pdf/jbpneu/v36n1/v36n1a02.pdf
10. Henriques M, Henriques J, Jacinto J. Acidente Vascular Cerebral no Adulto Jovem: A Realidade num Centro de Reabilitação. Revista da Sociedade Portuguesa de Medicina Física e de Reabilitação 2015; 27(1): 9-13. Available at: https://spmfrjournal.org/index.php/spmfr/article/view/180/106
11. Paes NL. Fatores econômicos e diferenças de gênero na prevalência do tabagismo em adultos. Ciênc. Saúde Colet. 2016; 21(1): 53-61. Available at: http://www.scielo.br/pdf/csc/v21n1/1413-8123-csc-21-01-0053.pdf
12. Martins PC, Carvalho MB, Machado CJ. Uso de medidas autorreferidas de peso, altura e índice de massa corporal em uma população rural do nordeste brasileiro. Rev. Bras. Epidemiol. 2015; 18(1): 137-48. Available at: http://www.scielo.br/pdf/rbepid/v18n1/1415-790X-rbepid-18-01-00137.pdf
13. Silva BM, Lin K. Perfil demográfico do acidente vascular encefálico no hospital universitário prof. Polydoro Ernani de São Thiago (florianópolis, sc) entre os anos 2001 e 2012. Arq. Catarin. Med. 2016; 45(2): 43-58. Available at: http://www.acm.org.br/acm/seer/index.php/arquivos/article/view/75
14. Malta DC, Santos MAS, Stopa SR, Vieira JEB, Melo EA, Reis AAC. A Cobertura da Estratégia de Saúde da Família (ESF) no Brasil, segundo a Pesquisa Nacional de Saúde, 2013. Ciênc. Saúde Colet. 2016; 21(2): 327-38. Available at: http://www.scielo.br/pdf/csc/v21n2/1413-8123-csc-21-02-0327.pdf
15. Lima, DF et al. Knowledge and use of medicinal plants for users of two basic health units. Rev. RENE 2014; 15(3): 383-90. Available at: http://www.revistarene.ufc.br/revista/index.php/revista/article/viewFile/1442/pdf_1
16. Veiga Junior VF. Estudo do consumo de plantas medicinais na Região Centro-Norte do Estado do Rio de Janeiro: aceitação pelos profissionais de saúde e modo de uso pela população. Rev. Bras. Farmacogn. 2008; 18(2):308-13. Available at: http://www.scielo.br/pdf/rbfar/v18n2/27.pdf
17. Antonio GD, Tesser CD, Pires R O M. Contributions of medicinal plants to care and health promotion in primary healthcare. Interface comun. Saúde educ. 2013; 17(46): 615-33. Available at: www.redalyc.org/service/redalyc/downloadPdf/1801/180128561010/6
18. Cardoso LS, Cezar-VazI MR, CostaII VZ, BonowI CA, AlmeidaI MCV. Promoção da saúde e participação comunitária em grupos locais organizados. Rev. Bras. Enferm. 2013; 66(6): 928-934. Available at: http://www.scielo.br/pdf/reben/v66n6/18.pdf
19. Fortuna CM, Matumoto S, Pereira MJB, Borges CC, Kawata LS, Mishima SM. Continuing education in the family health strategy: rethinking educational groups. Rev. Latinoam. Enfermagem 2013; 21(4): 990-7. Available at: http://www.scielo.br/pdf/rlae/v21n4/pt_0104-1169-rlae-21-04-0990.pdf

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