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DIAGNÓSTICO SITUACIONAL DAS CONDIÇÕES DE SAÚDE EM UMA UNIDADE DE SAÚDE DA FAMÍLIA NO OESTE DO PARANÁ: RELATO DE EXPERIÊNCIA

SITUATIONAL DIAGNOSIS OF HEALTH CONDITIONS IN A FAMILY HEALTH UNIT IN WESTERN PARANÁ: AN EXPERIENCE REPORT

DIAGNÓSTICO SITUACIONAL DE AFECCIONES DE SALUD EN UNA UNIDAD DE SALUD FAMILIAR EN EL OESTE DE PARANÁ: RELATO EXPERIENCIA

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Resumo

A territorialização e o diagnóstico situacional constituem ferramentas centrais para o planejamento em saúde na Atenção Primária, especialmente no âmbito da Estratégia Saúde da Família, ao permitirem a compreensão das condições de vida, dos determinantes sociais da saúde e das necessidades da população adscrita. No contexto da formação médica, essas estratégias também assumem papel relevante na integração ensino–serviço–comunidade. Este estudo tem por objetivo descrever e analisar, em perspectiva formativa, a experiência de construção de um diagnóstico situacional em uma Unidade de Saúde da Família, destacando sua contribuição para o planejamento local e para a formação médica. Trata-se de um relato de experiência acadêmico-assistencial, de natureza descritiva, com abordagem qualitativa e quantitativa, desenvolvido no contexto do Programa de Integração Ensino-Serviço-Comunidade (PIESC III). A experiência envolveu a construção de um diagnóstico situacional a partir da análise de dados secundários do e-SUS APS, entrevistas com informantes-chave e observação em campo, com organização dos resultados em perfis territoriais. O diagnóstico evidenciou características institucionais, territoriais, demográficas, socioeconômicas e epidemiológicas da população adscrita, bem como fragilidades relacionadas à incompletude de registros nos sistemas de informação e à organização do processo de trabalho, como microáreas descobertas e limitações na cobertura assistencial. A integração entre dados quantitativos e qualitativos permitiu uma leitura ampliada do território e das necessidades em saúde. O diagnóstico situacional mostrou-se uma ferramenta relevante para o planejamento em saúde na Atenção Primária,

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ao mesmo tempo em que evidenciou limites relacionados à qualidade da informação e às condições organizacionais do serviço. No campo da formação médica, a experiência contribuiu para o desenvolvimento de competências voltadas à análise crítica do território, à compreensão dos determinantes sociais da saúde e à integração ensino–serviço, fortalecendo uma formação alinhada aos princípios do Sistema Único de Saúde.
Palavras-chave: Atenção Primária à saúde; Território; Diagnóstico Situacional; Relato de Experiência.

Abstract

Territorialization and situational diagnosis are central tools for health planning in primary care, especially within the Family Health Strategy, as they enable an understanding of living conditions, the social determinants of health, and the needs of the registered population. In the context of medical education, these strategies also play a significant role in the integration of education, service, and community. The purpose of this study is describe and analyze, from an educational perspective, the experience of developing a situational diagnosis in a Family Health Unit, highlighting its contribution to local planning and medical education. This is a descriptive report of an academic-clinical experience, employing both qualitative and quantitative approaches, developed within the context of the Teaching-Service-Community Integration Program (PIESC III). The experience involved developing a situational diagnosis based on the analysis of secondary data from e-SUS APS, interviews with key informants, and field observations, with the results organized into territorial profiles. The assessment highlighted institutional, territorial, demographic, socioeconomic, and epidemiological characteristics of the enrolled population, as well as weaknesses related to incomplete records in information systems and the organization of work processes, such as uncovered micro-areas and limitations in healthcare coverage. The integration of quantitative and qualitative data provided a broader understanding of the territory and health needs. The situational assessment proved to be a relevant tool for health planning in Primary Care, while also highlighting limitations related to the quality of information and the organizational conditions of the service. In the field of medical education, the experience contributed to the development of competencies focused on the critical analysis of the territory, the understanding of the social determinants of health, and the integration of teaching and service, strengthening an educational approach aligned with the principles of the Unified Health System.
Keywords: Primary Health Care; Territory; Situational Diagnosis; Experience Report.

Resumen

La territorialización y el diagnóstico situacional constituyen herramientas fundamentales para la planificación sanitaria en la Atención Primaria, especialmente en el marco de la Estrategia de Salud Familiar, ya que permiten comprender las condiciones de vida, los determinantes sociales de la salud y las necesidades de la población atendida. En el contexto de la formación médica, estas estrategias también desempeñan un papel relevante en la integración entre enseñanza, servicio y comunidad. El objetivo de este estudio es describir y analizar, desde una perspectiva formativa, la experiencia de elaboración de un diagnóstico situacional en una Unidad de Salud de la Familia, destacando su contribución a la planificación local y a la formación médica. Se trata de un relato de experiencia académico-asistencial, de naturaleza descriptiva, con un enfoque cualitativo y cuantitativo, desarrollado en el contexto del Programa de Integración Enseñanza-Servicio-Comunidad (PIESC III). La experiencia consistió en la elaboración de un diagnóstico situacional a partir del análisis de datos secundarios del e-SUS APS, entrevistas con informantes clave y observación sobre el terreno, con la organización de los resultados en perfiles territoriales. El diagnóstico puso de manifiesto las características institucionales, territoriales, demográficas, socioeconómicas y epidemiológicas de la población atendida, así como las deficiencias relacionadas con la falta de exhaustividad de los registros en los sistemas de información y con la organización del proceso de trabajo, como las microáreas sin cubrir y las limitaciones en la cobertura asistencial. La integración de datos cuantitativos y cualitativos permitió obtener una visión más amplia del territorio y de las necesidades en materia de salud. El diagnóstico situacional se reveló como una herramienta relevante para la

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planificación sanitaria en la Atención Primaria, al tiempo que puso de manifiesto limitaciones relacionadas con la calidad de la información y las condiciones organizativas del servicio. En el ámbito de la formación médica, la experiencia contribuyó al desarrollo de competencias orientadas al análisis crítico del territorio, a la comprensión de los determinantes sociales de la salud y a la integración entre la enseñanza y el servicio, fortaleciendo una formación alineada con los principios del Sistema Único de Salud.
Palabras clave: Atención Primaria a la Salud; Territorio; Diagnóstico Situacional; Relato de Experiencia.

1. Introduction

Primary Health Care (PHC) represents the organizing foundation of the Brazilian health system, being considered the main gateway for users into the Unified Health System (SUS). Currently, PHC is governed by the National Primary Care Policy (PNAB), which establishes the guidelines for the organization of health care in the country, based on the principles of universality, comprehensiveness, and equity (Brasil, 2022a).

In this context, PHC acts in addressing the most frequent needs of the population through actions of promotion, prevention, diagnosis, treatment, and rehabilitation, focusing on both the individual and the collective. According to the Pan American Health Organization (PAHO, 2021), primary care should be the first level of contact for individuals with the health system, and it must be accessible, continuous, and a coordinator of care. For this, it is essential to operate within delimited territories, allowing for the planning and execution of actions consistent with the local reality (Mendes, 2019).

Among the management instruments of PHC, the situational health diagnosis stands out as an essential tool for an in-depth understanding of the territory and the enrolled population. The situational diagnosis is a systematic process of gathering and analyzing data that reveal the social, demographic, sanitary, and institutional characteristics of a given area. It is a strategic stage in the planning of health actions, as it allows teams to identify problems and establish priorities for interventions (Figueroa da Silva et al., 2021).

For this instrument to achieve its effectiveness, the diagnostic process must be constructed in a participatory, interdisciplinary, and continuous manner. The collaborative perspective among health professionals, managers, the community, and

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students promotes a more sensitive analysis of the social and sanitary vulnerabilities affecting the population. Starfield (2002) already highlighted that, in addition to the essential attributes of PHC — such as access and longitudinality —, it is fundamental to incorporate community orientation into the daily routine of services. This is only possible with a deep recognition of the territory and the social dynamics of the families served.

In this sense, territorialization is inseparable from the situational diagnosis. Colussi and Pereira (2016) argue that the territory is not just a geographic space, but a field for the production of bonds, knowledge, and practices. Thus, knowing the territory is also recognizing its subjects, their stories, and their social determinants of health. The absence of qualified information about the population hinders the development of coherent strategies, weakening the service's response to the real needs of the community (Giovanella et al., 2021).

In view of this, the situational diagnosis in PHC constitutes an indispensable management tool for overcoming merely palliative care models, allowing action planning to be based on the concrete reality of the territory (Ribeiro et al., 2008). By conducting the survey and analysis of local data, health professionals can identify not only biological and epidemiological needs, but also social ones (such as sanitation, housing, and security) that condition the population's illness process. An in-depth understanding of regional, institutional, and political specificities enables the definition of priorities and the efficient application of resources, ensuring that health interventions are, in fact, resolutive and aligned with the principles of the SUS.

Beyond the technical aspect, the construction of the diagnosis must be understood as a process of participation and dialogue that strengthens the bond between the health team, managers, and the community. The effectiveness of the Family Health Strategy (FHS) depends on this permanent interaction with the environment and with the various social actors, given that the sharing of information and active listening enable the unit to be a space for the production of comprehensive care. Therefore, the situational diagnosis is not limited to the simple collection of indicators; it configures an instrument for reorganizing teamwork that qualifies user

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access and promotes continuous improvement in the quality of life in the assisted territories (Silva et al., 2016).

This study aims to describe and analyze, from a formative perspective, the experience of constructing a situational diagnosis in a Family Health Unit, highlighting its contribution to local planning and medical education.

2. Methodology

This is an academic-care experience report, descriptive in nature, with a quantitative and qualitative approach. The experience report is understood as a modality of scientific production that describes and critically analyzes a professional or academic experience, articulating practice and theoretical foundation, especially relevant in the fields of Public Health and health education (Daltro; Faria, 2019; Minayo, 2014).

The study was conducted within the scope of the Education, Service, and Community Integration Program III module (PIESC III) of the Medical course, at a Family Health Unit (USF) located in a territory assigned to PHC in Western Paraná. It focused on the characterization of the territory and the team's work process, for formative purposes and to support local planning, not aiming to produce generalizable epidemiological inferences.

The elaboration of the situational diagnosis occurred through insertion into the territory and monitoring the activities developed by the health team, enabling an understanding of the organization of services and the living conditions of the enrolled population. The process was based on the experience in the practice setting and on direct *in loco* observation, allowing for the identification of aspects of the territory, infrastructure, and work process that are not always included in the information systems.

The practical activity of student insertion into the USF was structured based on the guide titled “Guides for the Construction of Profiles for the Local Situational Diagnosis,” made available in the PIESC III module, which guides the construction of

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territorial, population, and organizational profiles of the Health Unit. This instrument allowed for the systematization of the information collected and the integrated analysis of the data, considering the social determinants of health, the teams' work process, and the characteristics of the territory.

Data collection was carried out on May 6 and 13, 2025. Secondary data were extracted from the e-SUS APS system on May 6, 2025, from the Individual Registration and Household and Territorial Registration reports. The following inclusion criteria were adopted: individuals registered as active in the territory at the time of extraction. Additionally, records with incomplete data were analyzed according to availability per variable, without imputation.

From these reports, institutional, territorial and environmental, demographic, socioeconomic, and epidemiological profiles were constructed. The institutional profile analyzed the physical structure, the functioning of the Unit, the composition of the teams, the management processes, and the articulation with the health care network. The territorial and environmental profiles considered the geographic, socio-environmental, and infrastructure characteristics of the territory; the demographic profile described the population composition; the socioeconomic profile addressed living conditions and social vulnerabilities; and the epidemiological profile identified the main conditions and risk factors, subsidizing the planning of health promotion, prevention, and care actions.

Quantitative data were organized in an electronic spreadsheet and subjected to descriptive analysis, with the calculation of absolute and relative frequencies. Records with incomplete data were included according to the availability of each variable, without performing imputation. The results were interpreted in light of the territorial context and the experiences lived during the development of the activities.

It is highlighted that the e-SUS APS data reflect care records, dependent on access to the service and professional recording, and are not directly comparable to population surveys. Care records refer to data coming from health services, reflecting the demand met, while population survey data cover individuals regardless of the

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search for care. Considering the differences regarding purpose, collection method, and potential biases inherent to each source, these specificities were considered in the analytical process, and no direct comparisons were made between the data sets.

As this is an experience report within the scope of teaching activities, without individual identification of users, ethical principles related to the use of secondary data and information confidentiality were respected.

3. Results

Institutional Profile

The analyzed USF was implemented in 2018, replacing a previously existing Unit in the territory, within a context of population growth in the catchment area. This reconfiguration process of the local service network expresses the movements of PHC adaptation to the demographic transformations of the territory, while simultaneously highlighting challenges related to the planning and organization of care delivery in medium-sized municipalities. Located in an urban area in the Western region of Paraná, the Unit operates exclusively according to the Family Health Strategy (FHS) model, assuming a central role in care coordination and the organization of the health care network.

The operation with extended hours, organized into multiple shifts under the *Saúde na Hora* (Health on Time) program, expands the population's access possibilities to services, especially for users with time constraints. On the other hand, the expansion of operating hours is associated with rearrangements in the work process, with implications for continuity of care, longitudinal bonding, and articulation between teams. The presence of multiple FHS and Oral Health teams expands care coverage and diversifies the actions offered, while demanding mechanisms for internal coordination and interprofessional communication.

The 40-hour weekly workload and the inclusion of professionals in permanent education actions constitute structuring elements of the work process at the Unit.

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Medical provision through a federal program contributes to the maintenance of assistance, although aspects such as professional turnover may influence the continuity of care. Management exercised by a professional from the team itself, with training in the field, configures a local work organization potentially closer to the service's demands, while the recent assumption of the role suggests a need for consolidating management processes.

From a structural point of view, the Unit presents accessibility and location conditions that favor the population's geographical access. The use of digital tools, notably the use of WhatsApp as a means of communication with users, expands the possibilities for contact and interaction, while introducing new dynamics into the teams' work process. The absence of formal instances of social participation during the analyzed period limits the systematic incorporation of community demands into the planning of health actions.

The lack of specialized medical care at the Unit reinforces its role as a gateway and care coordinator within the attention network, with a dependence on regulation flows for access to other levels of care. The presence of a multiprofessional support team, such as a nutritionist and a social worker, expands the possibilities for addressing health needs, although the organization of these actions on an occasional basis may influence their continuity in the territory.

Territorialization, structured into micro-areas, constitutes a central element of work organization in the FHS. However, the presence of uncovered micro-areas, associated with the absence of professionals, impacts the monitoring of families, the establishment of bonds, and health surveillance actions. This condition relates to the team's capacity to identify needs and organize interventions in the territory.

The Unit also functions as a space for teaching-service integration, receiving undergraduate students from public higher education institutions, contributing to practical experience and reflection on health work in PHC. The absence of interns and residents, in turn, delimits the scope of this integration. The situational diagnosis was developed with one of the Unit's teams, allowing for the systematization of

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information regarding the territory and the work process, as well as the identification of aspects that influence the organization of care in the analyzed context.

Territorial/Environmental Profile

The territory assigned to the team participating in the experience is located in an urban area of a medium-sized municipality in Western Paraná, characterized predominantly by residential use and a recent process of urban expansion. This territorial dynamic expresses a growth pattern that does not always occur concurrently with the expansion of urban infrastructure and public services, producing intra-urban inequalities in access to goods and services.

According to the e-SUS APS system records, the territory comprises 691 properties, mostly residential. However, the territorial reconnaissance visit made it possible to identify the presence of relevant social facilities, such as schools, daycares, and religious institutions, as well as vacant lots not registered in official systems. This discrepancy suggests limitations in the territorial registration process and highlights the continuous dynamic of territorial transformation, with repercussions on the organization of health actions.

Regarding accessibility, the territory is served by public transport, with a bus stop located near the USF, favoring geographical access to services. Most roads present adequate conditions for circulation; however, barriers related to mobility were observed, such as narrow sidewalks, lack of curb ramps, and uneven pavement, with potential implications for the displacement of people with reduced mobility, the elderly, and users with disabilities.

The analysis of household characteristics indicates a predominance of masonry constructions with finishing and a high proportion of owned homes, suggesting relative housing stability. Nevertheless, field observation revealed environmental weaknesses, such as damaged sidewalks, accumulation of solid waste, and the presence of vacant lots, especially in areas further from the Unit. These elements relate to environmental conditions that may influence the occurrence

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of health issues and reflect inequalities in urban maintenance. Afforestation, although present on main roads, appeared limited in other areas of the territory.

As for water supply, wide coverage of the public network is observed; however, the analysis of the type of treatment of the water consumed indicates the use of untreated or inadequately treated water in part of the households, configuring a condition of sanitary vulnerability with potential repercussions on the health of the population.

The availability of electricity is predominant in the territory; however, reports of irregular public lighting at certain points, obtained through interviews with key informants, indicate aspects related to the use of urban spaces and the circulation of the population.

In the scope of sanitation, a significant portion of households has access to the sewage network or septic tanks, although rudimentary cesspools were also identified, in addition to gaps in available records. Waste disposal occurs mostly through regular collection; however, the observation of improper disposal in vacant lots and public roads highlights the coexistence of distinct practices in the territory.

The presence of domestic animals in households, associated with the circulation of stray animals on public roads, constitutes a relevant aspect in the context of health surveillance, especially regarding zoonoses and environmental conditions.

Concerning social facilities, the territory has small-scale local commerce, contributing to the neighborhood's economic dynamics. No formal instances of social participation directly linked to the USF, such as a Local Health Council, were identified during the analyzed period, which limits the institutional spaces for community participation in the observed context.

Based on the situational diagnosis and the experience in the territory, aspects related to the organization of territorial and household registration, environmental

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conditions, and service access dynamics were identified and discussed within the scope of teaching-service activities. The experience enabled students to problematize these issues, favoring the articulation between systematized data and the reality observed in the territory.

In this context, teaching-service integration served as a space for reflection on the work process in Primary Health Care, contributing to the understanding of the social determinants of health and the conditions that influence the organization of care in the analyzed territory.

Demographic Profile

The analyzed team has a registered population of 3,406 individuals, of whom 2,625 are active and 781 have been discharged from the registry, indicating population dynamics within the territory. Among active users, a slight predominance of the female sex is observed, with 1,414 individuals (53.9%), compared to 1,211 of the male sex (46.1%).

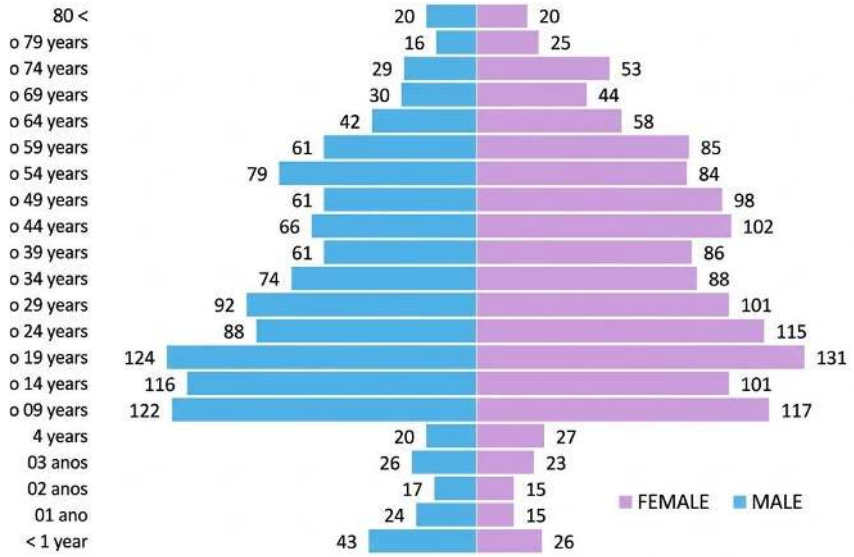
Regarding self-declared race/color, a predominance of mixed-race (*pardo*) people is identified (43.9%), followed by white (41.5%), while black, yellow, and indigenous populations appear in smaller proportions. The presence of records without information stands out (10.6%), which limits more detailed analyses of this variable in the territory. Regarding nationality, the majority of users are native Brazilians (98.5%), with the presence of foreigners corresponding to 1.5%.

The analysis of the population pyramid indicates a higher population concentration in the age groups from 5 to 19 years old, showing a predominance of children and adolescents in the territory. A significant participation of the population between 25 and 44 years old is also observed. The contingent of individuals aged 60 or over, although proportionally smaller, presents a relevant presence, with a slight female predominance in the older age groups (Figure 1).

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Figure 1: Age pyramid of the population assigned to the FHS team of a USF in Western Paraná.



Source: Prepared by the authors.

In the context of the developed experience, the analysis of the demographic profile was used as a basis for discussing the characteristics of the territory and possible health demands, within the scope of teaching-service integration activities. The concentration of children and adolescents, the significant presence of young adults, and the participation of the elderly population were problematized by the students in relation to the organization of actions in Primary Health Care.

The female predominance among users and the age composition of the territory were also discussed in the formative process, considering their implications for service utilization and care organization. Similarly, aspects related to racial diversity and the presence of foreign users were analyzed based on available data, although limited by the incompleteness of records, especially in the race/color variable.

The identification of incomplete registrations was incorporated into the reflections on the use of information systems in the daily routine of Primary Care,

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highlighting its influence on the reading of the territory and the understanding of the characteristics of the assigned population. In this sense, the experience enabled the articulation between quantitative data and the observed reality, contributing to the development of a critical analysis of the territorialization process and the use of health information.

Socioeconomic Profile

The socioeconomic profile of the population assigned to the team was described based on the records from the Individual, Household, and Territorial Registration modules of the e-SUS APS system, whose data are presented in Tables 1 and 2. A high proportion of incomplete records is observed in some variables, which influences the interpretation of the population's living conditions in the territory.

Table 1 – Socioeconomic profile of the population assigned to the studied team, USF in the Western region of Paraná

Variable	N	%
Family income*		
Up to 1 minimum wage	99	18,25
Between 1 and 2 minimum wages	132	24,35
Above 2 minimum wages	25	4,61
Not informed	286	52,77
Education level		
Up to Elementary school	866	32,95
High school	415	15,81
Higher education	53	2,02
No formal education	174	6,62

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Not informed	1.117	42,56
Private health insurance		
Has insurance	59	2,25
Does not have insurance	2525	96,19
Not informed	41	1,57
Homelessness		
Homeless citizen	0	0,00
Not informed	2625	100
Sexual orientation		
LGBTQIAPN+ population in the territory	5	0,19
Non-LGBTQIAPN+ (heterosexual)	310	11,81
Sexual orientation not informed	2310	88

N = ABSOLUTE NUMBER
% = PERCENTAGE

Source: Prepared by the authors.

* Percentages calculated based on valid records for the income variable (n = 542).

Note: Percentages were calculated based on the total records available for each variable. Incompleteness is observed in some variables, which may result in differences between the total number of registered individuals and the sum of the presented categories.

Regarding family income, of the 542 available records, 99 (18.25%) refer to an income of up to one minimum wage, 132 (24.35%) between one and two minimum wages, and 25 (4.61%) above two minimum wages. It is noteworthy that 286 registrations (52.77%) did not provide this information. Among the valid records, a higher concentration is observed in the lower income brackets.

Regarding health insurance coverage, 59 users (2.25%) reported having a private plan, while 2,525 (96.19%) do not, indicating a predominance of the use of public health services among the assigned population.

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Concerning education level, the data distribution indicates a higher frequency of individuals with schooling levels up to high school, considering the available categories. However, a significant proportion of records without information is observed (13.87%), which limits more detailed analyses. It is also noted that 53 individuals (2.02%) reported having a higher education degree and 174 (6.62%) no formal education.

Regarding homelessness, there are no records of individuals in this condition; however, all registrations (100%) are without information filled in for this variable, which prevents its analysis in the context of the territory.

In terms of sexual orientation, 2,310 records (88%) do not present this information. Among the completed registrations, 310 individuals (11.81%) were registered as not belonging to the LGBTQIAPN+ population, while 5 (0.19%) self-declared as belonging to this population. The high proportion of uninformed data limits the analysis of this variable in the territory.

Table 2 – Occupational status of the population assigned to the studied team, USF in the Western region of Paraná

Occupational Status	N	%
Formal employment	393	14,97
Unemployed	196	7,47
Retiree/pensioner	181	6,89
Does not exercise labor activity	551	20,99
Not informed	1304	49,68

N = ABSOLUTE NUMBER
% = PERCENTAGE

Source: Prepared by the authors.

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Regarding occupational status, 393 individuals (14.97%) have formal employment, 196 (7.47%) are unemployed, 181 (6.89%) are retirees or pensioners, and 551 (20.99%) declared they do not exercise labor activity. It is observed that 1,304 records (49.68%) do not present this information, which limits the characterization of the productive insertion of the assigned population.

Epidemiological Profile

The epidemiological profile of the assigned population was described considering the 2,625 active users linked to the team during the analyzed period. The systematization of these data enabled the identification of the main health conditions recorded in the territory, within the context of the activities developed in the teaching–service integration.

As shown in Table 3, a higher frequency of chronic non-communicable diseases is observed, with emphasis on excess weight (18.28%), arterial hypertension (15.54%), and diabetes mellitus (5.98%). These data were analyzed by the students as part of understanding the health profile of the assigned population.

Table 3 – Epidemiological profile of the population served by the FHS, USF in the Western region of Paraná

General Health Situations	N	%
Total people	2625	100
Bedridden	18	0,69
Tuberculosis	5	0,19
Homebound	51	1,94
Pregnant woman	31	1,18
Smoker	209	7,96
Uses alcohol	70	2,67
Uses drugs	39	1,49
Diabetes	157	5,98

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Hypertension	408	15,54
Overweight	480	18,28
Has or had cancer	36	1,37
Had a stroke (CVA)	25	0,95
Had a mental health problem reported by a health professional	70	2,67
Had a heart attack (MI)	19	0,72
Had a hospitalization in the last 12 months	96	3,66
Uses medicinal plants	80	3,85
Has some respiratory disease	108	4,11
Asthma	35	1,33
COPD	8	0,30
Has heart disease	67	2,55
Has or had kidney problems	55	2,10
Disability (general)	94	3,58
Hearing impairment	18	0,68
Visual impairment	7	0,26
Physical disability	43	1,63
Intellectual/cognitive disability	25	0,95

N = ABSOLUTE NUMBER
% = PERCENTAGE

Source: Prepared by the authors.

Among the recorded behavioral risk factors, smoking corresponded to 7.96% of the users, while the use of alcohol and other drugs was identified in 2.67% and 1.49%, respectively. There were also 70 individuals (2.67%) recorded with a history of mental health problems reported by a health professional.

Regarding specific conditions, cases of tuberculosis (0.19%), asthma (1.33%),

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and chronic obstructive pulmonary disease – COPD (0.30%) were identified, in addition to records of heart attack (0.72%) and stroke (0.95%). The presence of bedridden (0.69%) and homebound (1.94%) users was also observed in the available data.

In the scope of women's health, 31 pregnant women were recorded (1.18% of the population). However, it was not possible to identify the gestational risk classification in the analyzed data, which limits the description of this variable.

In general, the data presented show the coexistence of chronic conditions, behavioral risk factors, and specific conditions in the territory. In the context of the experience, this information was used as a basis for discussing the work process in Primary Health Care, allowing for the articulation between information system records and the reality observed in the territory.

Additionally, the presence of incomplete records in some variables was incorporated into reflections on the use of health information, especially regarding the potential and limitations of information systems in supporting territorial analysis.

4. Discussion

Considering the institutional profile of the USF, significant structural advances are observed regarding accessibility and service organization, such as the extended operating hours until 10:00 p.m., as provided by the *Saúde na Hora* program, and the presence of accessible infrastructure. These aspects reinforce the attribute of access in PHC, as described by Starfield (2002). However, challenges persist for the effective implementation of longitudinality of care, especially due to the lack of coverage in five micro-areas and the insufficient number of Community Health Agents (ACS), which compromises continuous monitoring and the bond with the assigned population.

The analyzed team covers the territory with three ACS, maintaining uncovered areas, which weakens territorial monitoring and home follow-up. The use of tools such as the WhatsApp application emerges as a complementary communication strategy

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with users; however, it does not replace home visits or the continuous presence of the team in the territory. Furthermore, the lack of an active Local Health Council and the limited performance of the multiprofessional support team (e-Multi) weaken the comprehensiveness of care, hindering intersectoral actions and user co-responsibility. According to Colussi and Pereira (2016), the absence of these mechanisms compromises the capacity of PHC to respond adequately to social and sanitary needs.

Regarding the territorial and environmental profile, a predominantly urbanized territory is identified, with mostly residential use and recent expansion, still marked by inequalities in access to infrastructure and basic services. Although the e-SUS APS system records information about the properties, *in loco* observation revealed discrepancies between the registration data and reality, such as the presence of unregistered social facilities. This finding reinforces the importance of continuously updating territorial information for health planning (Brasil, 2021).

In relation to urban mobility, the territory has public transport and roads in good condition. However, physical barriers, such as narrow sidewalks, uneven pavement, and the lack of curb ramps, limit safe displacement, especially for the elderly and people with disabilities. PAHO (2021) highlights that urban accessibility constitutes a relevant determinant for equitable access to health services.

As for housing conditions, masonry construction with access via paved roads predominates. However, the presence of vacant lots, waste accumulation, and low afforestation in peripheral areas highlight environmental weaknesses that can impact public health. According to PAHO (2021), degraded urban environments are associated with a higher occurrence of health issues, especially in contexts of vulnerability.

Regarding basic sanitation, although most households are connected to the public water supply network, 258 residences consume water without adequate treatment, posing a potential health risk. According to the IBGE (2022), this situation is frequent in peripheral urban areas and demands integrated actions of surveillance

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and health education.

Solid waste collection occurs regularly in most of the territory; however, the presence of trash and debris in public spaces requires continuous attention due to the potential for vector proliferation. This condition reinforces the need for articulation between the UBS, urban services, and health surveillance (PAHO, 2021).

The presence of animals in 334 households, associated with free circulation on public roads, increases the risk of zoonoses. According to the National Health Plan (Brasil, 2020), it is the responsibility of PHC to develop strategies articulated with the zoonosis sector for the prevention and control of these conditions.

Furthermore, the absence of community facilities linked to the UBS is observed, such as local health councils, which limits social participation. Law No. 8.142/1990 and the PNAB reinforce the importance of social control in action planning (Brasil, 2022b).

In the demographic profile, a slight female predominance (53.9%) is observed, in line with national data (IBGE, 2022). Regarding race/color, self-declaration as mixed-race (*pardo*) and white predominates, with a significant percentage of records without information (10.6%), which may indicate weaknesses in recording and possible processes of invisibilization.

The age pyramid shows a higher concentration between 5 and 44 years old, indicating demands focused on the young and adult population. The elderly represent 322 individuals, requiring continuous monitoring. The low proportion of young children suggests a population aging trend.

In the socioeconomic profile, markers of vulnerability stand out, such as low income, unemployment, and low private health insurance coverage (2.2%), reinforcing the dependence on the SUS (Brasil, 2017). Low education levels, predominant among users, may interfere with the understanding of health guidelines (IBGE, 2020). The incompleteness of data also limits more in-depth analyses.

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The presence of food insecurity, even if occasional, indicates situations of vulnerability that demand articulation with social assistance, according to the FAO definition (2021).

The high proportion of missing information on sexual orientation (88%) is highlighted, which limits the visibility of specific groups and the planning of equitable actions, as pointed out in the National Policy for Comprehensive Health of the LGBTQIAPN+ Population (Brasil, 2023).

In the epidemiological profile, a predominance of chronic conditions and modifiable risk factors is observed, such as arterial hypertension (15.54%), diabetes mellitus (5.98%), smoking (7.96%), and overweight (18.28%). These data reinforce the centrality of PHC in monitoring these conditions.

The observed prevalences are lower than the estimates from population surveys, such as VIGITEL (Brasil, 2022b; Paraná, 2023). However, this difference should be interpreted with caution, since e-SUS APS data reflect care records, dependent on service access and prior diagnosis, and are not directly comparable to self-reported data.

Regarding the work process, the presence of uncovered micro-areas and the reduced number of ACS impact longitudinal monitoring. These aspects may be related to work management difficulties, such as turnover and professional provision.

The absence of social participation spaces also limits the incorporation of community demands into local planning.

The e-SUS APS data must be analyzed considering their limitations, as they reflect care records and not population estimates.

In the field of medical education, the experience contributed to the development of competencies related to territorial analysis and social determinants of health, in addition to favoring teaching–service integration.

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Finally, it is noted that although 31 registered pregnant women were identified, the lack of information regarding gestational risk classification limits the analysis of prenatal care and highlights weaknesses in data recording. According to the PNAB (Brasil, 2022b), the monitoring of pregnant women constitutes a central element of PHC and must be qualified.

5. Conclusion

The construction of the situational diagnosis enabled an expanded understanding of the territory and the health conditions of the assigned population, highlighting both strengths and weaknesses related to the organization of the work process and the quality of health records. The findings reinforce the role of this tool in supporting local planning in Primary Care by favoring the articulation between epidemiological information and the reality experienced in the territory.

In the scope of medical education, the experience proved to be strategic for the development of competencies related to the critical analysis of the context, the understanding of the social determinants of health, and the integration of teaching–service–community, contributing to a more reflective, contextualized formation committed to the principles of the Unified Health System (SUS).

As limitations, the descriptive and localized nature of the experience stands out, which restricts the generalization of the findings, in addition to the dependence on secondary data from e-SUS APS, which are subject to incompleteness and inconsistencies in the records. Additionally, the absence of some variables and the limitation in the standardization of information may have influenced the analysis performed.

It is recommended that future studies expand the use of combined methodological approaches, with greater qualitative depth and integration of different data sources, as well as investigations in other territorial contexts, in order to compare realities and strengthen the production of evidence on the use of situational diagnosis for both health planning and medical education.

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