Analysis of factors influencing and conditioning social participation in Primary Health Care

Análise dos fatores que influenciam e condicionam a participação social na Atenção Primária à Saúde

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ABSTRACT This study is aimed at identifying and analyzing the factors that influence and condition the decision to participate in Local Health Commissions, participatory spaces located in the Basic Health Units (Unidades Básicas de Saúde – UBS). Twenty-one members were interviewed and data were analyzed using the Collective Subject Discourse technique. The idea of participation was verified in the users' discourses as a means for the population to access the functioning of the UBS and to the commission itself. Workers used the principles of primary care to justify their participation. Managers, on the other hand, aware of the importance of these forums for users, seek to develop democratic and supportive management practices.

KEYWORDS Social participation. Primary Health Care. Health policy.

RESUMO *O objetivo do estudo foi identificar e analisar os fatores que influenciam e condicionam a decisão de participar nas Comissões Locais de Saúde, espaços participativos localizados nas Unidades Básicas de Saúde (UBS). Foram entrevistados 21 conselheiros, sendo os dados analisados pela técnica do Discurso do Sujeito Coletivo. Verificou-se nos discursos dos usuários a ideia de participação como meio de acesso da população ao funcionamento da UBS e da própria comissão. Os trabalhadores justificaram sua participação por meio dos princípios da atenção primária. Já os gestores, percebendo a importância desses fóruns para os usuários, procuram desenvolver práticas gerenciais democráticas e solidárias.*

PALAVRAS-CHAVE *Participação social. Atenção Primária à Saúde. Política de saúde.*

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Introduction

The International conference on Primary Health Care, held in Alma-Ata in 1978, commended the community participation in different moments of health care planning and implementation. This conference understood health as a fundamental human right, based on a state of thorough physical, mental and social welfare. In this context, Primary Health Care (Atenção Primária à Saúde – APS) would be the basis for a new health care model, able to reorganize health systems (OPAS, 2008).

Primary Care can be understood as a

> set of health actions at both the individual and the collective levels, comprising the promotion and protection of health, preventing injuries, the diagnostic, the treatment, the rehabilitation, the reduction of damages and sustained health conditions. (BRASIL, 2012, P. 19).

It should be pointed out that, in Brazil, during the process of its construction, the Unified Health System (Sistema Único de Saúde – SUS) was renamed as Primary Health Care.

In Belo Horizonte, APS comprises the Basic Health Units (UBS) and is organized based on the definition of territories where sanitary conditions must be under the responsibility of their UBS (BELO HORIZONTE, 2016). Among UBS guiding principles are universality, integrality, accessibility, assistance coordination, and as to the community, bonding and participation (BRASIL, 2012). APS should thus be oriented to the community, by means of intimate knowledge of people's health needs, which involves their engagement and participation in decisions about the collectivity's health (GIOVANELLA; MENDONÇA, 2012).

The Family Health Strategy (Estratégia Saúde da Família – ESF), an APS intervention modality, was implemented in Belo Horizonte in 2002. The current municipality's population is of 2,385,639 inhabitants, 85.6% of which are assisted by ESF in 150 UBS, and 588 Family Health Teams (Equipes de Saúde da família – EqSF) (BELO HORIZONTE, 2016). At the UBS, EqSF carry out actions to receive users by means of programmed attendance of children, adults and elderly clients, besides spontaneous demands. They also provide medical and odontological assistance, child care, immunization, prenatal and pharmaceutical assistance, plasters, booking for specialized attendances, collection for laboratory exams, delivery of exams' results and electrocardiograms.

It can thus be easily noticed that the UBS is a meeting place for users, health professionals, managers and the community. This is why Local Health Commissions (Comissões Locais de Saúde – CLS) were created at each UBS, to be SUS's participative structures closer to the population. Among CLS attributions are proposing, following up and verifying the implementation of health policies in the region comprised in each UBS (CMSBH, 2014).

As one of its main attributes, primary attention is the first contact or the front door to the health system, aiming at guaranteeing the resolution of the most frequent and relevant health problems occurring in the territory (BRASIL, 2012). To meet that goal, the first requisite is the primary attention system to be accessible to the population. The CLS, as well as the UBS, must also firmly stand for the preferential and accessible front doors to attain population participation (OLIVEIRA; DALLARI, 2015).

For that reason, the inclusion of new social actors by means of the involvement of the community is not subject to the parity principle. According to its Unified Internal Rules, CLS is not a parity commission: it includes the unit' manager, UBS workers e all the users who live and reside in the area covered by the UBS (CMSBH, 2014). Commissions meetings are open to the community and all those who are present are entitled to speak up, so the number of members is not predetermined. On the other hand, the Commissions' board of directors, yearly

elected by the plenary, is composed by four members: two representatives of the users, one representative of the workers and the health unit's manager.

It can be noticed in this context that the CLS represents an innovative public space, with its own characteristics, which value the enlargement of the public sphere as an element of democracy. The theoretical reference of the study is based on Habermas (1989), who stresses the importance of the public sphere to guide and control the quality of decision-making processes by means of debates among citizens.

The purpose of this study was to identify and analyze the factors influencing and conditioning the decision to participate in a APS as a means to participate in CLS.

Methodology

This is an empirical descriptive study with a qualitative approach: one single case study involving more than one analysis unity (YIN, 2010). The selection of analysis unities resulted from an invitation to District Health Councils of Belo Horizonte to participate in the research, indicating their most active CLS. Out of the nine District Councils, two – East and Center-South – promptly accepted the invitation. The CLS indicated present opposite Social Vulnerability Index (Índice de Vulnerabilidade Social – IVS) – respectively, very high risk and low risk (BELO HORIZONTE, 2008).

The IVS, created by the Municipal Health Secretariat (Secretaria Municipal de Saúde – SMSA), associates population-based indicators, such as dwelling conditions and income, with health indicators, such as children mortality, stratifying the population in low, medium, high and very high risk (BELO HORIZONTE, 2008). For this study, a CLS with very high IVS risk was selected, located in the Center-South sanitary district, including three unities of analysis *(chart1)*.

Chart 1. Characterization of the selected Local Health Commissions

Indicated by the District Council	Basic Health Unit	Regional/ Sanitary District	Prevailing Risk (IVS)
Yes	A	East	Very high
Yes	B	Center-South	Low
No	C	Center-South	Very high

Twenty-one members of the Local Health Commission were interviewed using the interviewing technic based on a semi-structured script. In each CLS selected, seven members were interviewed: the manager, three representatives of the users and three representatives of the health professionals, chosen considering their frequent attendance to the meetings. The UBS director represented the manager. Users are individual representatives who represent themselves and/or collective representatives, organized in district associations that seek for improvements in public services. Local UBS workers are represented by medical professionals: physicians, dentists,

nurses, social workers, nursing assistants, agents working in endemic diseases and community health agents.

As a complementary technique, participant observation was employed with the use of a Field Diary. The research took place from February to July 2014, and was previously approved at Brazil Platform (Plataforma Brasil), CAAE: 18186813.6.3001.5140.

Data provided by the interviews were analyzed using the Collective Subject Discourse technique (Técnica do Discurso do Sujeito Coletivo – DSC) (LEFÈVRE; LEFÈVRE, 2003), which tries to make clear a given representation in a discourse strategy. Key expressions (selected parts of verbal material of each statement that best describe its content) and central ideas (synthetic formulations that describe the meaning(s) present in the material and in sets of answers by different individuals, where one may identify similar or complementary meanings) were identified and DSC were then constructed. It is important to remark that, for the construction of the discourses panel, an option was made for the identification of key-expressions and central ideas in each segment of participation in the CLS.

Results and discussion

In order to identify and analyze factors influencing and conditioning the decision to participate, the following open question was used: *"You have decided to be a member at the Local Health Comission, right? How did it happen? Please tell us!" (chart 2)*

Chart 2. Synthesis of central ideas

	Users' segment
A	Participates in the daily work at the Health Center
B	Participates in order to get acquainted and informed
C	Participates to pose demands
D	Participates to ensure constitutional rights
E	Difficulties to participate
	Workers' segment
F	Works in the unit and is part of the community
G	Participates to help other people
H	Inherent to the profession
I	Takes part in the process
J	Participates in decision-making
K	Difficulties to participate
	Managers' segment
L	Participates to improve the reality at the working site
M	Enjoys participating

Users' segment

A – PARTICIPATES IN THE DAILY WORK AT THE HEALTH CENTER

DSC – *We're participating in daily life at the health center and the health commission, we see the development of the work and even the reason for this commission. All residents can come and participate. They have voice! They can talk about their feelings [...]. There are questions, answers, just as it should... here, during the meeting...*

B - PARTICIPATES TO GET ACQUAINTED AND INFORMED

DSC – *It's good to participate when it's about health! Because when you participate... if someone asks you what's happening there* [in the local commission], *what's going on in health, you can explain. And if you do not participate, you can't talk about it, because you know nothing, you're not informed about it...*

C – PARTICIPATES TO POSE DEMANDS

DSC – *It is easier, you are attending the meetings and when you need to pose demands... it's easier, isn't ... because you know everything that's happening there. I wanted to participate to demand improvements [...] I have my limitations... I can't write very well [...]. But I really enjoy participating! And the manager is a kind of person, like, you know... very friendly and all that... [...] she enjoys chatting with us and explaining, which is even better! Teaching, you know? ... because we are new, not in age, but in what we are doing. She is different, she sits and explains... and that makes a big difference!*

D – PARTICIPATES TO ENSURE CONSTITUTIONAL RIGHTS

DSC – *I believe that all this* [the SUS] *is already a conquest, but unless you keep fighting, you conquer, but don't carry it on. So, you have to fight ... [...]. Each community must be united to look for what they think is really good for them. Not only for you, for half a dozen people, but for the entire community, because the community is very deprived of this assistance.*

Alma-Ata Declaration used to idealize APS as primary care based in suitable methods and technologies, scientifically proved and socially acceptable; access to APS should be warranted to every individual and every family in the community by means of their full participation and assuming knowledge democratization (OPAS, 2008). This is how the Discourse of the Collective Subject (Discurso do Sujeito Coletivo – DSC) in Group A emphasizes the notion of an open public sphere for all those who want to participate and to be entitled to speak-out. Deliberative theorists qualify as truly democratic the possibility offered to all participants to express themselves in decision processes, building up opinions and wishes.

CLS are forums open to all individuals concerned, entitled with the right to speak-out and vote; therefore they fulfill what is proposed by the Sanitary Amendment, to "change all public health beneficiaries into voice and vote" (LABRA, 2009, P. 183). Nonetheless, the collective subject A only calls attention to the right to speak. This fact was explained using the participant observation technique, which noticed that the practice of decision-making usually involved agreements, rather than voting.

According to the Unified Internal Rules of the Local Health Commissions (CMSBH, 2014), attributions of Local Members include follow up and supervision of services offered by the UBS, besides proposing improvements.

Damasceno, Brito e Monteiro (2010) point out that, in order to exert social control, being acquainted with the dynamics of health services is indispensable. Thus, the Collective Subject in group B understands participation as a tool to acquire knowledge and information – i.e., participation as an empowering model aimed at conquering knowledge to intervene in decisions that affect life in the community (PEREZ *ET AL. APUD* BISPO JÚNIOR; MARTINS, 2014).

Collective Subject C recognizes that *"I have my limitations... I can't write very well [...]"*. Therefore, one may verify progress related to granting voice to those who have less education and less technical knowledge, promoting the inclusion of social groups traditionally excluded from political processes (COELHO, 2011). As to the concern *"... because we are new, not in age, but in what we are doing",* Pateman (1992) states that participation is responsible for the promotion of the necessary qualities for its exertion: the more the individuals participate, the more they become able to do it.

This Collective Subject appraises the manager's participation, represented by a female manager who is prepared to *"chat, explain and teach",* which, according to this subject, *"makes a big difference"*. Côrtes (2009) remarks that state agents are decisive for the definition of councils' functioning conditions. Since these are forums where relations among actors are markedly asymmetric, managers are responsible for divulging the forums' activities and to guarantee availability of both resources and information for the accomplishment of those activities (COELHO, 2011).

Again according to Collective Subject C, taking part in the meetings is a pathway to keep informed. In this sense, one of the attributions of CLS is precisely to "keep informed on the projects related to health in the area comprised by the UBS" (CMSBH, 2014, P. 2), making it easier to pose demands aimed at the improvement of services and of life and health conditions in the community. Giovanella *et al.* (2009) conceive APS as a strategy that, besides being able to organize the health system, can also respond to population's needs, which requires the concept of health as a social right.

In this context, Collective Subject D considers SUS as a conquest. In fact, the promulgation of 1988 Federal Constitution is a turning point in the history of Brazilian democracy, particularly considering social rights and citizenship. That new Federal Constitution did recognize health as a fundamental human right and did entail its provision to social and economic policies, aiming to reduce damage risks, as well as to warrant universal and equitable access to health actions and services, not only for the recovery of health, but also for its protection and promotion. One can say those conquests result from the 'fight' of the Movement for Brazilian Sanitary Reform.

However, this same collective subject mentions the need to *"fight even when it is already a right that is assured under the Constitution"*. Although 1988 Constitution, did establish a legal basis for equal rights, what is observed is inequality in the fruition of those same rights. In daily life, that inequality keeps in place different standards of democracy. For upper and middle classes, rights and the possibility of speaking up and requiring them are recognized, while the poorest citizens face an exhaustive journey to be able to use, even if only partially, the rights announced as available. These citizens are treated as beggars who are granted a favor, at most (ESCOREL; AROUCA, 2016).

Although it is important to take into account improvements in the quality and honesty of health expenditure and management, one may observe that universal and good quality assistance, as promised by the Constitution and expected by the population, requires increases in public expenditures (COSTA, 2017).

Repeated budget reductions, leading SUS to chronic sub-financing, are hampering

the accomplishment of its constitutional aims and principles (COSTA, 2017). As already reported here, when it comes to people's real life, health is the target of one of the most frequent complaints by the population: *"because the community is very deprived of this assistance"*. Unfortunately, the future is also menaced by the Constitutional Amendment 95 (Emenda Constitucional – EC), which establishes maximum limits for public expenditures. It is estimated that this *EC* will withdraw from SUS resources approximately R$400 billion in the course of 20 years, considering a GDP annual growth at 2.0% and a 4.5% variation of the IPCA (National Index of Prices for the Consumer).

E – DIFFICULTIES TO PARTICIPATE

> DSC – *I think, also, that we are ageing and getting tired, and eventually we will have to quit, right? But while there are no others to replace us, because the youngest [...] are not interested... if we leave, you can expect it will be over!*

This discourse unveils the presence in the population of a feeling of lack of interest regarding participative practices (BISPO JÚNIOR; MARTINS, 2014), evidencing the fragility of the social basis necessary for the functioning of the participative model, as a consequence of the lack of a minimum popular organization. According to Labra (2009, P. 177),

> it can't yet be stated that citizens are involved in important and generalized ways with common interest issues, that they are supportive and tolerant, and that engaged in civic organizations that embody and reinforce those values.

In this context, Serapioni (2013) remarks the evaluation of the 30 years post-Alma-Ata, which assigns relevance to the challenge posed by the insufficient involvement of communities with health issues, particularly when it comes to the poorest ones.

With the expression *"we are ageing"*, the Collective Subject of group E calls attention to the profile of the users' segment, where female participation prevails and the mean age is 60 years.

Workers' Segment

F – WORKS IN THE UNIT AND IS PART OF THE COMMUNITY

> DSC – *I decided to be a local health member due to the importance of the commission for the community. I work in the community and I am part of it* [community], *I am an ACE (Agente de Combate a Endemias), an Agent in the Combat of Endemic Diseases, thence my wish to participate in the meetings and to be a Local Health Member.*

G – PARTICIPATES TO HELP OTHER PEOPLE

> DSC – *I have been working here as an ACS* [Communitary Health Agent – Agente Comunitário de Saúde] *for 11 years. Since my arrival, I'm a maniac in helping people. So, I started to come to the meeting [...] and I kept coming, I came to be part of it. Every now and then, I bring demands... because they are not pleased with the situation, I discuss, I invite people to come. I think it is good to participate because my goal is to stick close, not only to earn money, but to help other people.*

H – INHERENT TO THE PROFESSION

> DSC – *Ahh!... I think this is inherent to the profession! I'm here at the* UBS... *a Local Commission, the community participating... I want to participate! I have to participate! I think that's due to the contact with local population that is attended here. I think this is quite typical for us, social*

workers. A Local Commission... it is important to be with them! ... to participate!... to listen!...

I – TAKES PART IN THE PROCESS

DSC – *I have decided to participate because I belong to the health system, to the community! I belong to the community as physician, I belong to the health team, right? So, there is no way I can miss being here, I'm part of the process!*

J – PARTICIPATES IN DECISION-MAKING

DSC – *I decided to participate because the Local Commission... it makes decisions, right?... regarding problems that we detect, both in the community and in the health center, and it forwards solutions. And since I'm a PSF* [Family Health Program] *nurse, I have daily contact with the community, here in the health center and in home visits. So I thought that my presence, my collaboration, was very needed here in the commission.*

Oliveira and Marcon (2006) emphasize that the social control in APS presents certain specificities, because professionals who work directly in the region – and therefore experience the users' local reality – must exert it. Furthermore, the discourses of Collective Subjects F and G have unveiled the presence of Agents in the Combat of Endemic Diseases (Agente de Combate a Endemias – ACE) and Community Health Agents (Agente Comunitário de Saúde – ACS) who are members of the Local Health Commission with double bond – that is, they are simultaneously health workers and residents in the region, they belong to the community. This proves that the team/community/family inter-relation is essential for the developing APS activities (OLIVEIRA; MARCON, 2006).

It should be stressed, however, that, in CLS, members who represent the workers' segment are not to be confused with representatives of the users' segment, since, according to the Unified Internal Rules of Local Health Commissions (CMSBH, 2014), users are those citizens who have no direct or indirect bonds with SUS network in Belo Horizonte.

With the expression *"Every now and then I bring a demand... because they are not pleased with the situation, I discuss, I invite people to come",* Collective Subject G shows how limited directives are for team work and social participation. According to Crevelim e Peduzzi (2005), those directives are, at a time, the consequence and the expression of relations between the target population, the service and the team. However, when an association is made between participating in CLS and helping others, Collective Subject G expresses his understanding of social control as a charitable practice. It is worth stressing that ESF directives consider participation and social control as strategies to accomplish principles that guide SUS procedures (OLIVEIRA; MARCON, 2006). Nonetheless, one can notice that SUS procedures are taken for philanthropic actions, which is contrary to its premise on health as a social and citizenship right.

The Health Ministry considers promoting mobilization and participation of the community as an attribution shared by all APS professionals, aimed at effective Social Control. Thus, the Collective Subject of groups H, I and J unveiled the participation of professionals – social worker, physician and male nurse – in CLS. In Brazil, the idea of APS commends the adoption of a work process supported by a multi-professional team working within a delimited territory, adding clients to the target population, registering and keeping close attention over the population living in the area under their responsibility.

In this sense, a research carried out by Giovanella *et al.* (2009) in Belo Horizonte

municipality showed that 85% of families registered did resort to the same health service for either assistance or prevention, confirming the principles of accountability regarding the population living in the area and bonds existing between users, workers and the APS service.

It's not just by chance that the Collective Subject of group H appraises participation: it provides the contact with target population. *"A Local Commission... it is important to be with them!... to participate!... to listen!..."*. Therefore, the health team must act as a mediator in the participative process, listening to the community when people tell out loud what are their wishes and opinions, stimulating them to make decisions aimed at common welfare (DAMASCENO; BRITO; MONTEIRO, 2010).

On its turn, the Collective Subject of group K recognizes the importance of CLS precisely as a space for decision-making – that is, a democratic public equipment where organized groups can influence and decide on governmental actions that are needed for collective welfare. Therefore, it is up to CLS members to discuss and look after solutions, at the CLS public level, for the main assistance and structural problems in the community (BISPO JÚNIOR; MARTINS, 2014). On the other hand, the Collective Subject of group I reveals regarding the community a feeling of belongingness: *"I belong to the community as physician"*. Gurza Lavalle and Isunza Vera (2011) observe the potential of participation in the development of the citizen's feeling of belongingness to the society, not only strengthening the constitution of political identities, but also legitimating the political institutions.

K – DIFFICULTIES TO PARTICIPATE

> DSC – *It wasn't really my choice, I think I was chosen! Those to be represented chose their representatives during the meeting; there were no candidates, there was no 'I want to...' [...] So, I became a member due to lack of options ... to lack of participation of workers from the unit. And I keep going! Unfortunately,* [the workers] *are always the same...*

Collective Subject of group K reports an election of Local Health Members (for the Commission) who would be representatives of the workers' segment. *"[...] at the time of the meeting there were no candidates, there was no 'I want to...' [...]"*. The technique of observing participants allowed us to confirm that in the CLS election process there is no composition among candidates. In both users and workers segments, names are suggested by those present in the meeting. It is important to stress that elections occur exclusively for the Board of Directors. As already explained, CLS considers members all those who are present in the meetings, workers and users pertaining to the UBS responsible for that territory. In the CLS studied, USB workers are not obliged to attend the meetings.

A different situation is described by Bispo Júnior e Martins (2014): studying Local Health Commissions in the municipality of Vitória da Conquista, they found out that UBS health professionals are forced to participate in the meetings. The authors also detected that a large number of health professionals are not motivated to participate, understanding the activities of the Local Commission as a further attribution in their overloaded working journey. In this sense, Collective Subject K regrets the fact that workers representatives *"are always the same"*.

Managers' segment

L - PARTICIPATES TO IMPROVE THE REALITY AT THE WORKING SITE

> DSC – *Deciding to become a member is deciding to be able to contribute, to help to improve*

the reality [...] along with the community. To improve services. Services offer and interaction with the community. To try to improve life for all those who rely on [...] this unit.

M – ENJOYS PARTICIPATING

DSC – *As a manager, you always have seat in the commission. This is one of the motives, and another... is that I enjoy participating, taking part in decisions, talking with with people, exerting a more democratic management. I think participating in the commission is a very enriching experience.*

The declining scenery of the economy, combined with the massacre of social rights, has directly led to the intensification of social inequalities (ESCOREL; AROUCA, 2016).

In conditions where deprivation and social exclusion are elements that determine health and life quality, promoting health must be synonymous of social transformation seeking for justice and inclusion (CARVALHO; GASTALDO, 2008). In this sense, Collective Subject L, a representative of the managers segment, views the "*decision to be a member as a strategy towards improving the reality",* which can be understood as facing social inequalities *"in partnership with the community"*. It's not by chance that, in APS, health is understood as not dissociable from the economic development, and the proposal is to confront social determinants in the health-disease process.

In order to accomplish that proposal, APS must operate using democratic and participative management practices (BRASIL, 2012). The Collective Subject of group M agrees with that idea, and emphasizes the pleasure of taking part by exerting *"a more democratic management"*. Coelho (2011) observes that political authorities can offer a favorable context for mobilization, favoring the inclusion of a larger number of citizens and promoting the dissemination of information which, as a consequence, leads to more productive public debate.

Conclusions

In the quest to identify and analyze factors influencing and conditioning the decision to participate, users' discourses brought out the perception of participation as a means for the population to access UBS functioning and the Local Commission itself. The study has also identified in the users' segment difficulties for participation that could be linked to socio-cultural and historical factors, such as lack of both participative tradition and civic culture, and the prevailing political culture. Yet, there are evidences of community engagement, though incipient, which, based on an empowerment process, brings to attention demands for good quality health care and the fulfillment of the universal right to health in the citizens' daily life, as prescribed by the 1988 Federal Constitution.

Workers recognize as difficulty the limited participation in the USB workers in this forum, and justify their participation by means of a multi-professional team, based on APS guiding rules.

Managers, in their turn, have evidenced concern regarding the community reality through a compulsory participation. In this sense, recognizing the importance of this forum for the users, they try to appraise and develop democratic and supportive management practices in APS.

Collaborators

AMC Oliveira worked in the design, data collection and analysis, and production of the paper; SG Dallari was the supervisor, collaborating as well for the critical revision and approval of the version to be published. ■

References

BELO HORIZONTE. Secretaria Municipal de Saúde de Belo Horizonte. *Relatório de gestão 2007.* Belo Horizonte: SMSA, 2008. Disponível em: <http://www.pbh.gov.br/smsa/arquivos/relatorio_de_gestao_final_24-04-2008.pdf>. Acesso em: 15 jul. 2015.

_____. *Relatório de gestão 2015.* Belo Horizonte, 2016. Disponível em: <http://portalpbh.pbh.gov.br/pbh/ecp/comunidade.do?evento=portlet&pIdPlc=ecpTaxonomiaMenuPortal&app=saude&lang=pt_BR&pg=5571&tax=15436>. Acesso em: 17 jan. 2017.

BISPO JÚNIOR, J. P.; MARTINS, P. C. Participação social na Estratégia de Saúde da Família: análise da percepção de conselheiros de saúde. *Saúde em Debate,* Rio de Janeiro, v. 38, n. 102, p. 440-451, jul./set. 2014.

BRASIL. Constituição (1988). *Constituição da República Federativa do Brasil*. Brasília, DF: Senado, 1988.

_____. Ministério da Saúde. *Política Nacional de Atenção Básica.* Brasília, DF: Ministério da Saúde, 2012.

CARVALHO, S. R.; GASTALDO, D. Promoção à saúde e empoderamento: uma reflexão a partir das perspectivas crítico-social pós-estruturalista. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 13, p. 2029-2040, 2008.

COELHO, V. S. P. Uma metodologia para a análise comparativa de processos participativos: pluralidade, deliberação, redes e politicas de saúde. In: PIRES, R. R. C. (Org.). *Efetividade das instituições participativas no Brasil: estratégias de Avaliação.* Brasília, DF: IPEA, 2011. p. 279-74.

CONSELHO MUNICIPAL DE SAÚDE DE BELO HORIZONTE (CMSBH). *Regimento Interno Unificado das Comissões Locais de Saúde*. Belo Horizonte: CMSBH, 2014.

CÔRTES, S. M. V. Conselhos e conferências de saúde: papel institucional e mudança nas relações entre Estado e sociedade. In: FLEURY, S.; LOBATO, L. V. C. (Org.). *Participação, democracia e saúde.* Rio de Janeiro: Cebes, 2009. p. 102-128.

COSTA, A. M. A saúde em tempos de golpe. *Saúde em Debate,* Rio de Janeiro, v. 41, n. 112, p. 5-8, jan./mar. 2017.

CREVELIM, M. A.; PEDUZZI, M. A participação da comunidade na equipe de saúde da família. Como estabelecer um projeto comum entre trabalhadores e usuários. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 10, n. 2, p. 323-331, abr./jun. 2005.

DAMASCENO, S. S.; BRITO, G. K. K.; MONTEIRO, C. H. Fomentando o controle social em rodas de conversa com usuários de uma unidade de saúde da família. *Saúde em Debate,* Rio de Janeiro, v. 34, n. 84, p. 59-66, jan./mar. 2010.

ESCOREL, S.; AROUCA, L. E. Democracia e participação: para além das dicotomias. *Saúde em Debate*, Rio de Janeiro, v. 40, n. esp., p. 39-48, dez. 2016.

GIOVANELLA, L.; MENDONÇA, M. H. M. *Atenção primária à saúde:* seletiva ou coordenadora dos cuidados? Rio de janeiro: Cebes, 2012.

GIOVANELLA, L. *et al*. Saúde da família: limites e possibilidades para uma abordagem integral de atenção primária à saúde no Brasil. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 14, n. 3, p. 783-794, maio/jun. 2009.

HABERMAS, J. *Consciência moral e agir comunicativo.* Rio de Janeiro: Tempo brasileiro, 1989.

LABRA, M. E. Política Nacional de Participação na Saúde: entre a utopia democrática do controle social e a práxis predatória do clientelismo empresarial. In: FLEURY, S.; LOBATO, L. V. C. (Org.). *Participação, democracia e saúde*. Rio de Janeiro: Cebes, 2009. p. 176-2003.

LAVALLE, A. G.; VERA, E. I. A trama da crítica democrática: da participação à representação e a accontabillity. *Lua Nova,* São Paulo, v. 84, p. 353-364, 2011.

LEFÈVRE, F.; LEFÈVRE, A. M. C. *O discurso do sujeito coletivo:* um novo enfoque em pesquisa qualitativa:

desdobramentos. Caxias do Sul: Educs, 2003.

OLIVEIRA, A. M. C.; DALLARI, S. G. Participação social no contexto da Atenção Primária em Saúde: um estudo de caso das Comissões Locais de Saúde do SUS de Belo Horizonte, *Physis,* Rio de Janeiro, v. 25, n. 4, p.1059-1078, out./dez. 2015.

OLIVEIRA, R. G.; MARCON, S. S. Trabalhar com famílias no Programa de Saúde da Família: a prática do enfermeiro em Maringá-Paraná. *Rev Esc Enferm USP,* São Paulo, v. 41, n. 1, p. 65-72, mar. 2007.

ORGANIZAÇÃO PAN-AMERICANA DA SAÚDE (OPAS). *Declaração de Alma-Ata*. Washington, DC, 2008. Disponível em: <http://www.legislacion.bvsalud.org/php/level.php?lang=pt&component=37&item=6>. Acesso em: 17 jan. 2016.

PATEMAN, C. *Participação e teoria democrática*. Rio de janeiro: Terra e Paz, 1992.

SERAPIONI, M.; SILVA, M. G. C. Avaliação da qualidade do programa Saúde da Família em municípios do Ceará: uma abordagem multidimensional. *Ciência & Saúde Coletiva,* Rio de Janeiro, v. 16, n. 11, p. 4315-4326, nov. 2011.

YIN, R. K. *Estudo de caso:* planejamento e métodos. 4. ed. Porto Alegre: Bookman, 2010.

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