

# Municipal Health Conferences: the organized social movement to create health interventions

CONFERÊNCIAS MUNICIPAIS DE SAÚDE: O MOVIMENTO SOCIAL ORGANIZADO NA  
CONSTRUÇÃO DE INTERVENÇÕES EM SAÚDE

CONFERENCIAS MUNICIPALES DE SALUD: EL MOVIMIENTO SOCIAL ORGANIZADO  
EN LA CONSTRUCCIÓN DE INTERVENCIONES SANITARIAS

Maria Marta Nolasco Chaves<sup>1</sup>, Emiko Yoshikawa Egyr<sup>2</sup>

## ABSTRACT

The objective of this exploratory study was to understand the discourse leading to the health intervention proposals approved during the Health Conferences held in Curitiba-PR between 1997 and 2007. The results show that the approved health interventions were related to epidemiological indexes, the funding of the system, the change of the health care model, and the participation of the organized social movement. To broaden the participation, discussions were carried out before the final session, in which the number of participants remained nearly constant. In the final remarks it was observed that no reviews were done regarding the determinants of the health-diseases process; there was a tendency to make individuals accountable for promoting changes in their reality, and the model of broadened participation allows for reflection on the representivity of social movements in the political decisions within the sector.

## DESCRIPTORS

Health Conferences  
Health Public Policy  
Primary Health Care

## RESUMO

Estudo exploratório que objetivou compreender o discurso das propostas aprovadas para intervenções em saúde nas Conferências de Saúde ocorridas em Curitiba-PR no período de 1997 a 2007. Os resultados demonstram que as intervenções em saúde aprovadas estiveram relacionadas aos índices epidemiológicos, financiamento do Sistema, reversão do modelo de assistência e participação do movimento social organizado. Para a ampliação da participação foram garantidas discussões ascendentes anteriores à plenária final, na qual se manteve um número de participantes quase constante. Nas considerações finais teve-se que não houve reflexão sobre os determinantes do processo saúde-doença; a tendência foi responsabilizar o indivíduo para promover mudanças na sua realidade e o modelo de ampliação da participação permite refletir sobre a representatividade dos movimentos sociais na decisão das políticas do setor.

## DESCRITORES

Conferências de Saúde  
Políticas Públicas de Saúde  
Atenção Primária à Saúde

## RESUMEN

Estudio exploratorio que objetivó comprender el discurso de las propuestas aprobadas para intervenciones sanitarias en las Conferencias de Salud acontecidas en Curitiba-PR entre 1997 y 2007. Los resultados demuestran que las intervenciones sanitarias aprobadas estuvieron relacionadas a los índices epidemiológicos, financiamiento del Sistema, reversión del modelo de atención y participación del movimiento social organizado. Para la ampliación de la participación fueron garantizadas discusiones ascendentes anteriores a la plenaria final, en la cual el número de participantes se mantuvo casi constante. En las consideraciones finales, se expresó que no existió reflexión sobre los determinantes del proceso salud-enfermedad; la tendencia fue responsabilizar al individuo para promover el cambio en su realidad, y el modelo de ampliación de la participación permite reflexionar sobre la representatividad de los movimientos sociales en las decisiones políticas del sector.

## DESCRIPTORES

Conferencias de Salud  
Políticas Públicas de Salud  
Atención Primaria de Salud

<sup>1</sup>Adjunct Professor of the Nursing Department, Federal University of Paraná. Curitiba, PR, Brazil. [mulasco@terra.com.br](mailto:mulasco@terra.com.br) <sup>2</sup>Full Professor of the Department of Collective Health Nursing at School of Nursing, University of São Paulo. CNPq fellow. [emiyeegy@usp.br](mailto:emiyeegy@usp.br)

## INTRODUCTION

Public social control aims to provide democratic societies with the ability to exercise the right of citizenship, in which representatives of organized social movements participate in the elaboration of public policies, together with other social entities, in order to meet the needs of individuals and society at large. In Brazil, discussions regarding popular engagement processes were initiated in the 1930's and 1940's, when public policies were created to offer each individual state the opportunity to voice an opinion on the infrastructure needed to supply the demands of productive, highly populated and industrial concentrations of people located in the outlying areas of Brazilian cities<sup>(1)</sup>. The scope of these needs included the access to goods, services and social-political rights denied to those not belonging to the ruling classes of society<sup>(2)</sup>.

In present day Brazil, the Health Councils are permanent decision-making bodies. Health conferences are regularly held in each area of government, aimed at consulting the representatives of different social segments regarding the healthcare needs of the population, in accordance with the regulations of the Unified Health System. The purpose of these conferences is to define the guidelines for each individual sector's public policies<sup>(3)</sup>. In the committees, councils and conferences, designed to encourage popular participation, the representatives of organized social movements are expected to express the demands of the people they represent, as well as to influence policy to meet the health needs of the people adequately. It should not be forgotten, however, that all interventions aimed at assisting the population at large are expected to be carried out by the public services<sup>(4-5)</sup>. In Brazil's representative democracy, these bodies of indirect participation are comprised of collegiate and deliberative groups, with the goal of establishing each sector's public policies. However, this is a relatively recent phenomenon, implemented slightly more than twenty years ago, and therefore needs to be expanded and deepened<sup>(6)</sup>.

In the past decades, the economic structural adjustment recommended by international agencies to aid developing nations has led some countries experiencing enormous social and economic challenges to adopt strategies aimed at meeting the demands of the low-income population. Brazil was one of these nations. The recommendation of strategies toward the settlement of economic reforms has created the so-called Minimum State; that is, according to neoclassical economic theories, the State abandons the position of inducing economic growth and social welfare and transfers this responsibility to the logic of the market<sup>(7)</sup>. Added to the absence of the State concerning the promotion of satisfactory life conditions

for all populations is the lack of preparation on the part of the representatives of organized social movements to claim for and conquer their rights and autonomy. Moreover, the difficulties faced by healthcare managers regarding their understanding of the role of councilors in the definition of public policies, as well as the lack of preparation regarding the follow-up of the application of the financial resources in the sector, should also be highlighted<sup>(8)</sup>.

Taking into account the above-mentioned restrictions and issues, the construction of a democratic, all-inclusive society requires that this process be reanalyzed, so that all social classes, as well as all ethnic, cultural and gender-based diversities, are cared for under the services provided by the State<sup>(9)</sup>.

Advancements in the healthcare sector are directly related to the economic and social policies that define the social determination processes of the health-disease continuum. Capitalistic societies are responsible for labor insertion and social reproduction; in other words, they are in charge of handling the life conditions of individuals, families and communities. These conditions allow individuals to meet their self-preservation and life preservation needs within a socially determined context, which concurrently determines their own needs<sup>(10)</sup>.

Based on the presupposition that the proposals approved by the Health Conferences and the interventions of the sector should be able to meet the health needs of communities and populations, the city of Curitiba (PR) has been promoting various Health Conferences since the beginning of the 1990's, in accordance with the recommended frequency (once every two years).

Thus, the present reflections were aimed at comprehending the discourse of the proposals approved during the Curitiba Health Conferences held between 1997 and 2007.

## METHOD

This is an exploratory, qualitative-based research. The exploratory phase of the research may be considered to be research itself, as it enables the construction of knowledge and responses to previously set hypotheses<sup>(11)</sup>. Exploratory studies allow the researcher to build knowledge and gather experiences regarding a given problem. Such knowledge can be used as a basis for the analysis of the eventual elements related to that problem, so that the next phase of the research can be developed<sup>(12)</sup>.

This study is founded on the Theory of Praxis Intervention in Collective Health Nursing (TIPESC in Portuguese), grounded on Historic and Dialectic Materialism (HDM)<sup>(13)</sup>. Based on its adopted world view, the TIPESC was proposed to the collective health field, which stands for the

Advancements in the healthcare sector are directly related to the economic and social policies that define the social determination processes of the health-disease continuum.

emergence of health intervention processes based on the comprehension of the social determination of the health-disease binomial. Therefore, the TIPESC provides nursing with a dynamic systematization profile that is able to capture, interpret and intervene in a given reality through the articulation between observed phenomena and social production and reproduction processes. Similarly to Objective Reality, the theory should be comprehended in its three dimensions, namely: the structural dimension, the particular dimension and the singular dimension. This allows the professional to identify the processes related to the health-disease profile observed in a defined collectivity, time and space. In its intervention in the reality, the TIPESC recommends that it be reinterpreted over and over again, so that the intervening instrument can be once again inserted into a dynamic movement.

The ethical aspects of the research project named *Evaluative competencies of the nurse in recognizing and coping with the healthcare needs of families*, from which this present study was drawn, was assessed by the Research Ethics Committee of the University of São Paulo's Nursing School and approved under resolution number 740/2008.

The documents were analyzed in light of the analytical categories of the theoretical references proposed by the six Final Reports of the Curitiba Health Conferences held in 1997, 1999, 2001, 2003, 2005 and 2007. The initial analysis showed that the documents presented significant differences regarding the systematization of data recording processes. Aiming to pinpoint the changes related to the issues addressed by the approved proposals, a thematic guideline was organized throughout the whole period in order to enable the organization of intervention groups related to specifically pertinent issues. The thematic analysis guideline was created following an exhaustive reading of the material. Later, the guidelines were applied to each report, seeking to identify whether or not a specific discussion took place during the event, and also to confirm eventual alterations to the approved proposals pertaining to each issue.

In order to comprehend the dimensions of the Objective Reality in terms of the specific approved health intervention proposals made during the Curitiba Health Conferences between 1997 and 2007, the study investigated the public policies that defined the organization of the local healthcare system – the structural dimension – and the characterization of Curitiba regarding economic, population and epidemiologic aspects, as well as the public health service network implemented during that period – the particular dimension.

## RESULTS

The Health Conferences debated the collective and individual character of interventions related to healthcare promotion and prevention, as well as the treatment of

various diseases, aiming to meet the needs of patients according to the specifics of their life cycle or disease; moreover, the meetings approached the concerns of health professionals regarding the environmental impact of social production and reproduction factors in the municipality. It was noted that the approved interventions predominantly focused on both the individual and on curative actions/treatment interventions that should be developed by the health services at all levels of complexity.

The conferences' discourse presented indirect collective interventions aimed towards fostering quality of life. A series of interventions aimed at preventing illness could also be identified in the documents. These types of interventions were more prevalent in the proposals approved during the last three Conferences (9<sup>th</sup>, 8<sup>th</sup>, 7<sup>th</sup>)<sup>(14-16)</sup>.

The following is the discourse presented at the 7<sup>th</sup> conference:

The theme: Conquest, advancements and challenges of the Unified Health System in Curitiba. Subtheme: Mental health, social control, intersectoriality, health rights, social security and financing, health-based labor, social security and health. The following proposals were approved: (...) Increase in the actions of the healthy life program, aiming to promote interventions in people's daily lives and to stimulate habit and attitude changes toward a healthy life style (...) Encourage, support and participate in projects that integrate governmental and non-governmental sectors, as well as civil society, aiming to improve quality of life and health conditions and seeking the social, economic and environmental self-sustainability of the Curitiba population (...)

The reports of these events reaffirmed the need to change behaviors and life styles adopted by individuals in regards to proposals concerning health promotion. In this sense, the proposals focused on the accountability of subjects for their choices and habits towards an improved quality of family and community life.

The reports presented a significant repetition of approved intervention proposals. Here is the explanation: the proposal was approved in response to the demands of a given group, according to life cycle characteristics; later, another very similar, sometimes identical proposal was approved in order to meet the demands of an at-risk group. The repetition also occurred regarding interventions that should be carried out in certain services based on technological levels of complexity. Examples supporting this observation include proposals related to the priority care of elderly people facing a life-threatening illness and the immediate recording of the same proposal when the discussions targeted ways in which elderly people should cope with the threat to their health when there was a high prevalence of illness in the group, as can be seen in the following fragments from the 9<sup>th</sup> Conference:

Advanced proposals to cope with the occurrence of diabetes in the population at large:

(...) comprehensive, multidisciplinary care in the various healthcare levels that takes into account degrees of risk toward the organization of hierarchical care based on a referral and counter-referral system. In high biopsychosocial risk situations, the care model must be carried out by means of case management processes, where self-care and the patient's adherence to the treatment plan toward controlling the disease are stimulated (...)

Advanced proposals to cope with the occurrence of arterial hypertension in the population at large:

(...) Implement case management in high-risk (biopsychosocial) situations within the Healthcare Unit's coverage area. Stimulate self-care and adherence to the treatment plan. Encourage the formation of physical activity groups coordinated by a health professional (...).

Advanced proposals for health promotion and control of illness in the aged population:

(...) Develop preventive actions to mitigate elderly people's health risk factors, such as the cardiovascular risk originating from hypertension, diabetes, obesity, sedentary lifestyle and tobacco addiction, among others. Develop actions toward preventing prevalent illnesses in aged populations (...).

In this case, the proposals sought to address the best method of systematization toward the elaboration and approval of intervention proposals under the logic of the Municipal Health Conferences, which presuppose a broad participation of organized social movements in the health-disease process. This all-embracing engagement subsidizes the establishment of public policies to cope with the health-related needs of various populations and also organizes the services provided by the sector, in accordance with the principles of the UHS<sup>(2-3)</sup>. The reports reveal difficulties in establishing the guiding axis of the collective discussion, as this type of debate seeks to enhance the participation of organized social movements, technicians, managers and service providers.

The approved proposals were consolidated by the guarantee of access and the enhancement of the scope of interventions carried out by primary healthcare services, pointing out a clear need to expand the Healthcare Community Agents Program (HCAP) and the Family Healthcare Strategy (FHS), in addition to changing the work conditions observed in local services, expanding healthcare teams through the increase of personnel, introducing new labor categories into the health labor process and, finally, encouraging the participation of organized social movements in the definition of health interventions in local services, as shown below.

The access to, and the enhancement of, the scope of interventions carried out by primary healthcare services:

Educational campaigns designed to inform the population regarding programs and services offered by the Healthcare Units (HUs) (...) Promote and enhance home-based

care interventions (medical-nursing) provided to families, thus enabling their continuity (...) Implementation of Family Healthcare Programs in all HUs (...) Ensure that the UHS provides the necessary care during the morning, afternoon and night periods (...) Train healthcare community agents and ensure the continuation of the project (...) (5th Conference).

The introduction of new categories:

Expand the physical education program to all healthcare units of the City Hall, under the guidance of the health professionals (physiotherapy and physical education) (...) (7th Conference).

(...) Implementation of pharmaceutical education programs regarding the prescribing of drugs to the elderly and the issue of polypharmacy (...) (8th Conference).

The engagement of the organized social movement in terms of defining health interventions in the local services:

Propose that local health councils promote waste reduction, reuse and recycling in the municipality (...) Propose that the Municipal Health Secretariat advertises and implements healthcare volunteer programs through the promotion of annual volunteer meetings (...) Implement mechanisms of participation for the Local Health Councils in the programs developed by the HU, especially regarding the promotion of healthcare and self-care actions (...) (7th Conference).

The healthcare professional was identified as being partially responsible for the development of health-based interventions, prevention of illness and patient's adherence to treatment. Adherence to treatment is dependent on the adopted lifestyle and the self-care status, aiming at promoting health and preventing illness. The contradictions observed in the discourse were found in the proposals that indicated the need for ensuring adequate funding for the sector, accessibility to other services at different levels of complexity, and the revision of the care model, among other issues that can become obstacles in the development of healthcare interventions on the part of the professional and the knowledge of the individual regarding the necessary care to maintain health.

The 4<sup>th</sup> Conference highlights were as follows:

(...) Increase financial support and other resources for the operation of the Municipal Healthcare System (...) Sensitize the healthcare teams regarding the relevance of embodying healthy life habits and carry out health-based educational programs in the communities (...).

The same Conference evidenced some difficulty regarding the comprehension of the true attributes of the sector, and which interventions were dependent on intersectoral cooperation in order to be carried out. This was due to the fact that whenever a given proposal was approved, the search for partners to carry it out was also commenced. This reality caused us to reflect on the con-

cept of partnership on which the healthcare interventions were based, as several of these interventions did not depend on other sectors for implementation, but rather on the health sector itself. Here is an example:

Intersectoral cooperation towards health promotion by means of the prevention of traffic accidents – to establish a program aimed at providing vehicle inspection bodies with a higher degree of strictness and control (...) Disclose pedestrian-related information concerning the prevention of traffic accidents (...) build pedestrian footbridges on BR 277, BR 116 and in other critical areas; place bus exhaust pipes on the upper rear of the vehicle, at the roof level, as a method of decreasing the amount of toxic gases inhaled by users [...] Collect and disclose statistical data regarding traffic accidents per district and major intersections, thus enabling data information to be fully uncovered (...). (4th Conference).

The sequence of the debates on intersectoral issues showed a misunderstanding of this principle. This fact can be clearly observed in the 7<sup>th</sup> Conference<sup>(16)</sup>, when Protection Networks were approved. The documents show that these entities should integrate health services with other local services, so that the necessary interventions aimed at altering the undesirable realities of some segments of the population – children, teenagers, aged people – could be made available.

Provide parents with collective awareness interventions and relationship education regarding the child and adolescent protection network (...) Encourage the implementation of a protection network for elderly people living in situations of abandonment, violence or ill-treatment (...). (7th Conference).

As for the organization of the municipal healthcare system, the discourses range from the services providing pre-hospital care up to those services that should be held responsible for more complex actions. Regarding pre-hospital care, the proposals debated during the 6<sup>th</sup> Conference<sup>(18)</sup> pointed out the implementation of the Trauma and Emergency Integrated Care Service (TEICS) and the Urgent Medical Care Service (UMCS) in order to provide support for pre-hospital emergency care processes, which had previously only been carried out in the 24-Hour healthcare units, which had become totally overwhelmed in terms of their care capacity.

Under a similar perspective, some approved proposals pointed out the need for the establishment of guidelines that could ground the interventions carried out by the professionals at the various levels of healthcare complexity. The 6<sup>th</sup> Conference<sup>(18)</sup> provides a good example of this matter, discussing the approval of the creation of the Health Service Integrated System (HSIS), so that integrated interventions could be carried out at different levels of the system in a more effective and efficient way.

(...) offer integrated services directed towards meeting the demands of populations located in the HUS coverage area; satisfaction of the population regarding the HSIS (...) Expansion and diversification of health care branches (...) intersectoral integration between health care services and other public policies (...) integration with the municipalities in the Metro Area (...) aiming to implement the UHS's principle of universality (...) enhancement of the outpatient department's decision-making capacity (...) articulation with social services (...) higher level of rationality of the HSIS (...) economic assessment of healthcare services (...) cost-benefit assessment of the healthcare-technological aggregate (...). (6th Conference).

In the process of defining the organization of the municipal healthcare system, the Conference's participants agreed that the management of public and accredited services should comply with the principles and guidelines established by the UHS in regards to the development of the interventions under their responsibility. Accordingly, the approved proposals recommended: the definition of the healthcare model be carried out within the services; an articulation with other sectors for the development of cooperative interventions – intersectorality; adequacy of the health service infrastructure towards the expansion of the healthcare coverage; guarantee of access for patients and hiring of professionals by means of civil servant exams in order to increase the existing number of employees; and insertion of new professional categories into the healthcare labor process.

A certain number of approved proposals presented interventions aimed at altering social determinants and requirements in the health-disease process; however, the following discussions showed a retreat in the direction of the proposal. This was because the majority of proposals referring to the social determination of illnesses either recommended interventions for groups and individuals at risk or affirmed that patients and their families should adopt a healthier lifestyle in order to prevent the threats to their health discussed in the conference.

Violence-related morbidity and mortality indexes were the focus of discussion from the 6<sup>th</sup> Conference onward<sup>(18)</sup>. The approved preventive-based interventions were aimed at combating violence against aged people, women, adolescents and children, as well as decreasing the mortality index of adolescents resulting from external causes. As for the latter, the Conference recommended an expanded analysis of these cases by means of the identification of the social-economic variables related to its determination.

(...) Broaden the protection network for victims of violence. Expand violence notifications against children. Implement care protocols toward women victims of violence. Implement the Information System for Violence Prevention (IS-VP). Encourage the population to adopt a healthy lifestyle (...) Recognize violence against women as a public health problem. Build an information network regarding violence against women and children (...) Insert intra-family vio-

lence as a criterion toward the identification of populations at risk, aiming at prioritized care within the HU (...) (6th Conference).

As for the finance issue in the municipal healthcare system, this theme was identified at all Conferences due to the fragility of the sector in guaranteeing resources to implement and maintain approved interventions. The search for financial resources at the legislative level in the different government spheres was recommended. In spite of the lack of defined financial resources in the sector, observed in the regulations of the Unified Health System throughout Brazil, proposals indicating the need to expand or implement interventions were approved at the Conference without clear knowledge of where the financial resources for their implementation would come from.

Regarding the application of resources in the sector, the 7<sup>th</sup> Conference<sup>(16)</sup> approved a proposal that held the Municipal Healthcare Council (MHC) accountable for overseeing the application of resources, as previously set out in regulations on the books since the beginning of the 1990's.

The revision of the current care model was pointed out at all of the Conferences. The issue was addressed both when it related to the interventions to assist individuals in coping with a given illness and when it referred to a healthcare intervention designed to meet the needs of individuals in a given phase of their life cycle. In this sense, the envisioned care model was created for the healthcare program, according to the Healthcare Programs established by the Ministry of Health. The adoption and updating of clinical protocols aimed at complying with the changes that took place in the sector's labor processes and improving the efficiency of the healthcare interventions provided were also approved. Under this perspective, the 6<sup>th</sup> Conference<sup>(18)</sup> proposed the implementation of nursing consults, as well as the *International Classification of Nursing Practices in Collective Health (ICNPCH®)*, as strategies to reverse the current care model in the primary healthcare programs.

The demand for training programs for the Secretariat's healthcare professionals could be observed in a great number of approved proposals. The need to improve professional knowledge in order to meet the organization's demands and the specificities of the interventions carried out in the public and accredited services was seen as a way to reverse the current care model. According to the analyzed reports, the desired model was based on the health program and required the development of the activities set out in the protocols. Thus, the training program referred to in several different proposals aimed to instrumentalize professionals, so that they could intervene in accordance with the sector's management programs and protocols.

The theme of social control was also present in several proposals at all Conferences due to the relevance of the

participation of organized social movements in the elaboration, organization and implementation of the event. The need to educate patients to enable them to participate in discussions regarding the population's health-related issues, as well as the Public Policies to be approved in order to meet those demands, were the major concerns recorded at the Conferences in this area. However, it was agreed that these training processes should be carried out by the healthcare service management itself, by means of permanent education projects.

During the ten years of the Conferences, the reports showed several changes in the manner in which they were organized. The documents of the 4<sup>th</sup> Conference<sup>(17)</sup> did not record the moments preceding the Conference's plenary. In later years, the reports revealed the collective moments preceding the Conference, aiming at expanding discussions and elaborating proposals<sup>(19)</sup>. Thus, the courses and the local and district conferences that preceded the plenary of the Municipal Conference ensured an increasing number of participants. The documents show that the records of these moments were significantly enhanced throughout time; hence, it is believed that there has been a wide distribution of opportunities for the engagement of organized social movements in all areas of the municipality. However, the number of participants in the Conference plenaries held steady, despite the population growth in the last years, as well as the improved organization of the conferences based on preparation and the enhancement of the proposals to the sector.

## DISCUSSION

The Conferences' documents showed that the systematization of the reports related to the approved proposals throughout the ten year-period analyzed by this study was improved. The content of the proposals shows that the discourse became closer to the healthcare reality in the municipality, based on epidemiologic and populational indexes. The results of the Conferences highlighted the repetition of different approved intervention proposals, justified by the need to develop actions to cope with distinct problems. As such, the discourse seemed to have its origins in the healthcare system's technical or managerial fields, not in the organized social movement. This finding agrees with the results of the 11<sup>th</sup> National Healthcare Conference, which points out the lack of preparation on the part of the representatives of the organized social movements to represent the population's interests in the definition of Public Policies<sup>(8)</sup>.

The strengthening of the councilors' academic and professional background was one of the approved proposals found in all Municipal Conferences; however, no record whatsoever was found regarding their preparation. Nonetheless, some records contradictorily showed that such preparation should be carried out by the managers of the sector. It is believed that the training programs organized

for healthcare councilors must focus on their autonomy in order to represent the people effectively, which was the purpose for which they were elected. Additionally, the academic and professional background of healthcare professionals must be enhanced by means of a training process that allows them to critically and reflexively comprehend the reality of the dimensions that surround them, in such a way that they are capable of understanding the social determination of the health-disease process in order to promote interventions that go beyond the mere identification of signs and symptoms of illness presented by people seeking healthcare services<sup>(9,13,20)</sup>.

The compliance with recommendations aimed to provide minimum care, or to an extent defined by the availability of resources, require the establishment of exclusion criteria<sup>(2,9)</sup>. In this sense, the analyzed discourse supported the logic of the healthcare program. In the majority, such a healthcare program is based upon the risk criterion; however, this profile poses several obstacles against the recognition of healthcare needs, as recommended by the Unified Health System.

It is up to the public power to regulate and predict the resources required to promote interventions that are capable of efficiently meeting the health needs of both patients and families. These interventions, in their turn, must be carried out by competent professionals. This has been the historical claim of the movement that supports Brazilian Sanitary Reform; thus far, it has not yet been achieved<sup>(2)</sup>. The major consequence of this lack of regulation can be the exhaustion of the capacity of the local healthcare services to provide answers for social determination processes that extend beyond the healthcare sector.

The advancements in the organization of the Healthcare System, according to achieved results, are related to the implementation and updating of protocols and programs designed to systematize health care in recent years<sup>(13,16)</sup>. Among the innovations we note the Curitiba Mother Program, the *International Classification of Nursing Practices in Collective Health (ICNPCH®)*, the single electronic report, the online disease notification system,

and the protection networks for victims of violence and ill-treatment.

The events' organizing committees made use of an increasing movement to guarantee greater participation and elaboration of proposals. Notwithstanding, the responsibility for the approval of forwarded proposals was placed in the hands of delegates present in the Conferences' final plenaries, whose numbers remained steady. The Conferences' organizers understand that it is necessary to put a limit on the number of people engaged in the process; however, it is worth reflection regarding how the above-mentioned profile could guarantee that the patients were represented in decision-making processes related to the interventions designed to meet their demands.

## CONCLUSION

In the analyzed Conferences, the themes of the approved intervention proposals referred to health threats that had already been identified in epidemiologic data. There has been no record of intervention proposals to encourage self-determination in the health-disease process. The discourses tended to make individuals accountable for choosing their own lifestyles and for their adherence to prescribed treatments, and also highlighted how healthcare professionals had been made partially responsible for eventual alterations in that reality. Some proposals were approved in spite of simultaneous discussions on issues such as the limited access to healthcare services, the urgent need of reversing the current health care model, and the lack of regulation of financial resources.

Finally, although it can be affirmed that the popular engagement in the healthcare Conferences has been both a conquest and a significant advancement in the healthcare sector, the process is still weak and evolving in its capacity to transform the discussions carried out in the sector; that is, to break through the discussion model grounded on health threats, which are in turn grounded on epidemiologic data, and move forward in discussions regarding the need to expand health care toward the care of the population segments represented in the Conferences.

## REFERENCES

1. Valla VV. Educação, saúde e cidadania: investigação científica e assessoria popular. *Cad Saúde Pública*. 1992;8(1):30-40.
2. Gohn MG. Empoderamento e participação da comunidade em políticas sociais. *Rev Saúde Soc*. 2003;13(2):20-31.
3. Carvalho IG, Santos L. Sistema Único de Saúde: comentários à lei orgânica da saúde (Lei 8.080/90 e Lei 8.142/90). São Paulo: Hucitec; 1992.
4. Moreira MR, Escorel S. Conselhos Municipais de Saúde no Brasil: um debate sobre a democratização da política de saúde nos vinte anos do SUS. *Ciênc Saúde Coletiva*. 2009;14(3):795-805.
5. Cohn A. Estado e sociedade e as reconfigurações do direito à saúde. *Ciênc Saúde Coletiva*. 2003;8(1):9-18.
6. Escorel S. Conselhos de Saúde: entre a renovação e a reprodução da cultura política. *Divulg Saúde Debate*. 2008;(43)23-8.

7. Cortes SMV. Construindo a possibilidade da participação dos usuários: conselhos e conferências no Sistema Único de Saúde. *Sociologias*. 2002;4(7):18-49.
8. Brasil. Ministério da Saúde; Conselho Nacional de Saúde. Relatório final da 11ª Conferência Nacional de Saúde: o Brasil falando como quer ser tratado: efetivando o SUS: acesso, qualidade e humanização na atenção à saúde e com controle social [Internet]. Brasília; 2000 [citado 2011 out. 22]. [http://conselho.saude.gov.br/biblioteca/Relatorios/relatorio\\_11.pdf](http://conselho.saude.gov.br/biblioteca/Relatorios/relatorio_11.pdf)
9. Breilh J. *Epidemiologia crítica: ciência emancipadora e interculturalidade*. Rio de Janeiro: Hucitec; 2006.
10. Heller A. *Teoría da las necesidades em Marx*. 2ª ed. Barcelona: Península; 1986.
11. Bardin L. *Análise de conteúdo*. Lisboa: Edições 70; 2008.
12. Triviños ANS. *Introdução à pesquisa em ciências sociais: a pesquisa qualitativa em educação*. São Paulo: Atlas; 1987.
13. Egry EY. *Saúde coletiva: construindo um novo método em enfermagem*. São Paulo: Ícone; 1996.
14. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório final da 9ª Conferência Municipal de Saúde - Saúde e Qualidade de Vida: Política de Estado e Desenvolvimento [Internet]. Curitiba; 2008 [citado 2011 out. 22]. Disponível em: [http://www.saude.curitiba.pr.gov.br/images/cms/arquivos/relatorios/relatorio\\_004.pdf](http://www.saude.curitiba.pr.gov.br/images/cms/arquivos/relatorios/relatorio_004.pdf)
15. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório final da 8ª Conferência Municipal de Saúde - A Participação Popular na Construção de um Viver Saudável [Internet]. Curitiba; 2005 [citado 2011 out. 22]. Disponível em: [http://www.saude.curitiba.pr.gov.br/images/cms/arquivos/relatorios/relatorio\\_005.pdf](http://www.saude.curitiba.pr.gov.br/images/cms/arquivos/relatorios/relatorio_005.pdf)
16. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório final da 7ª Conferência Municipal de Saúde – 15 anos do SUS Curitiba: Conquistas, Avanços e Desafios. Curitiba; 2003.
17. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório da 4ª Conferência Municipal de Saúde - Sistema Único de Saúde: Saúde Pública com Qualidade. Curitiba; 1997.
18. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório da 6ª Conferência Municipal de Saúde – Plano Municipal de Saúde de Curitiba 2002-2005. Curitiba; 2001.
19. Curitiba. Secretaria Municipal de Saúde; Conselho Municipal de Saúde. Relatório final da 5ª Conferência Municipal de Saúde – SUS no III Milênio em Defesa da Vida. Curitiba; 1999.
20. Chaves MMN, Larocca LM, Peres AM. Collective Health Nursing: the construction of critical thinking about the reality of health. *Rev Esc Enferm USP* [Internet]. 2011 [cited 2011 Oct 22];45(n.spe 2):1701-04. Available from: [http://www.scielo.br/pdf/reeusp/v45nspe2/en\\_11.pdf](http://www.scielo.br/pdf/reeusp/v45nspe2/en_11.pdf)