Participative management in Primary Health Care: an essay on an experience in a vulnerable urban territory

Gestão participativa na Atenção Primária à Saúde: ensaio sobre experiência em território urbano vulnerável

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ABSTRACT Participatory management, although instituted in the norms of the constitution of the Brazilian Universal Health System (SUS), still faces challenges to be effective in practice at a local level, especially in complex urban territories, aiming at community strengthening and social participation. This essay aims to present and discuss aspects of a participatory management experience in a vulnerable territory, mediated by Primary Health Care. This experience of health co-management was developed between 2009 and 2013 in Manguinhos, a municipality of Rio de Janeiro. From the managers' reports and the technical materials produced, the implementation of strategies analyzed were the mobilization to create a local intersectoral management council and those of information, education, and communication in health supported by institutional supporters and by the family health teams. We concluded that democratic managerial and sanitary practices can be developed through social technologies, which value participative and shared management among workers-users-management.

KEYWORDS Participative management. Social participation. Primary Health Care. Health policy.

RESUMO *A gestão participativa, embora instituída nas normativas de constituição do Sistema Único de Saúde, ainda encontra desafios para efetivação em âmbito local, especialmente em territórios urbanos marcados por violência e pobreza. O ensaio objetivou apresentar e discutir aspectos de uma experiência de gestão participativa em um território vulnerável, mediada pela Atenção Primária à Saúde. Essa experiência de cogestão da saúde foi desenvolvida entre 2009 e 2013 em Manguinhos, no município do Rio de Janeiro. A partir do relato de gestores e de materiais técnicos produzidos, analisou-se a implementação de estratégias, tais como a mobilização para criação de um conselho gestor intersetorial local e aquelas de informação, educação e comunicação em saúde suportadas por apoiadores institucionais e pelas equipes de saúde da família. Concluiu-se que práticas gerenciais e sanitárias democráticas podem ser desenvolvidas por meio de tecnologias sociais, que valorizem a gestão participativa e compartilhada entre trabalhadores-usuários-gestão.*

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

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Introduction

To those who think reality not only as it is but also as it should be. This is the opening sentence of the book 'Health Councils in Brazil: citizen participation and social control' (our English free translation) by master Antônio Ivo de Carvalho, to whom this essay is dedicated. Besides his theoretical contribution and tireless activism on the policy of participation in the SUS, he was our great institutional leader and formulator of the conceptual bases of the experience reported here; whose objective image can be summarized in his periodic statement: *we need to radicalize the participatory management of Teias!* (Text-dedication of the authors).

The creation of the Unified Health System (SUS) as a public policy demarcated by the 1988 Brazilian Constitution, and the advent of a new pattern of social policies, were instituted amid democratic reconstruction movements in the country in the late 1980s[1]. The universal right to health and the role of the State in this guarantee were reaffirmed, incorporating spaces and devices for the democratization of the management of the health system into the political-institutional structure of the SUS. Formal channels for sharing the decision-making process in the relationship between State and society, such as health councils, were established, and social participation was also encouraged in other community spaces[2-4].

The concept of participation took on different meanings, depending on the context in which it was operated and the relationships established between the State and society. Teixeira[5] presents four dimensions of the concept: the pedagogical, which refers to critical education aimed at political emancipation and the exercise of active citizenship; the symbolic, which is related to the construction of a collective identity of a specific group (social movement). Furthermore, we have the concept of political gain, understood as a guarantee of rights insofar as social policies distribute assets and power. Finally, we have the dimension of social control in managing public policies, which should be exercised when formulated.

The inclusion of participation as a theme in the reformist programs of several countries from the 1960s onwards aimed to oppose massification, bureaucratic centralization, and monopolies of power, the democratic principle according to which all who are affected by social and political measures must participate in the decision-making process, whatever the political or economic model adopted[6].

In the health field, participation is historically referred to and corresponds to different ways of understanding the State-society relationship and the health-disease-care process, thus assuming different taxonomies. Carvalho[7] affirms that the idea of 'community participation' that emerged in the early twentieth century in North American community health centers considered that health action should be less coercive and hygienist and advanced in the dynamic understanding between man and the environment, its cultural and social factors. In Brazil, lacking democratic tradition and political participation, this proposal lost its participatory dimension in the official framework. However, in the 1950s and 1960s, it gave rise to counter-hegemonic health projects, such as community organization laboratories, which is how, alongside and in the shadow of the official proposal of community participation, experiences were developed and progressively became radicalized. They ended up taking on their identity as proposals for popular participation[7].

With the promotion of 'popular participation', social inequality should not be considered just an element of description or distribution of health problems but rather a key to its explanation[7]. The author argues that, in the 1970s and 1980s, besides the technical dimension aimed at solving the main problems of the health sector, the political dimension as a tool of struggle for expanding access to health care[7] was appreciated. New participation practices emerged in the 1980s through

collegiate and representative administrations based on the right of citizenship. With the Citizen Constitution, participation as demagoguery or pedagogy gives way to participation as citizenship[7] and 'social participation'. It refers to individuals and social groups whose diverse interests and projects integrate citizenship and disputes with equal legitimacy space and service by the state apparatus. From this perspective, social participation in the SUS was organized in the ensuing years, with frameworks such as Health Councils and Conferences in the three spheres of government. In such a constitutional design, social participation imposes the explicit and formal presence of the State and the several social segments to make the diversity of interests and projects visible and legitimate[7].

The establishment of a social policy agenda focused on social inclusion stands out in the national administration in the 2000s, expressed, for example, in the Growth Acceleration Program (PAC) from 2007 to 2010, which, in its health sector aspect, valued the role of Primary Health Care (PHC) in the territories of that urban intervention.

The first edition of the National Primary Care Policy (PNAB)[8] was enacted in 2006, and the Integrated Health Care Territories (Teias)[9] was designed in 2007. They were revised in the following years by the new edition of the PNAB in 2011[10], which established the concept of comprehensive PHC, centered on the Family Health Strategy (ESF), operated in its attributes (access, bond, comprehensiveness, coordination, family and community guidance, and cultural competence) and integrated into the Health Care Network. Also noteworthy in this decade are the virtuous debates about the social determinants of health[10], which were related to the Health Promotion[11] benchmarks and its principles of equity, social participation, autonomy, empowerment, intersectoriality, sustainability, comprehensiveness, and territoriality[11]. Such conceptions were also found in the National Policy for the Humanization of Care and Management in Health[12], which had guidelines such as 'participatory management and shared management', principles that included the 'leadership, shared responsibility, and autonomy of subjects and groups'; devices such as 'institutional support' and 'collegiate managers' to encourage solidary and group exchanges between managers, workers, and users[12].

The bases of Teias were conceived (in 2009) in the Manguinhos territory in the swarm of such policies inducive of participatory health management to reorient PHC. As one of its founding conceptions, promoting the active and creative participation of people from a given living territory – with their knowledge, practices, culture, and history – developed in the daily routine of health practices was allegedly strategic[13,14].

Santos[15] argues that challenges ranging from the insufficiency of Western rationality lie between the instituted and the instituting practices of expanding participation at the local level, for which particular or local realities would be inexpressive for the dominant global scale, to the process of building collective interest, through its existing participatory devices[15].

In this sense, challenges are highlighted, such as i) how users' representation in participatory management spaces is organized, which presupposes the activation of bilateral communication channels between the people designated to participate and those who represent them[16]; ii) overcoming individual indignation towards prioritizing and solving problems, sharing powers and knowledge[17]; iii) the difficulty of Local Health Councils to interact with other bodies and sectors operating in the territory, limiting their mediating role between community and municipal management[18]; iv) in collegiate meetings, emphasizing agendas restricted to technical or professional actions and a specific tension with the various stakeholders in the network[19].

Reaffirming participatory management as a way of operating public policy means

working to connect the community forces with social movements and concrete practices in the daily life of health services[20]. It depends on creativity, willingness, and the ethical-political-institutional-social standing of those who use it.

A particularity to be highlighted in participatory management refers to the social context of the territory, notably in the settings of social exclusion, plagued by violence that limits democratic social participation. In these contexts, we should think of new arrangements to promote the organization of civil society to create opportunities for participation and participatory management. Promoting citizen social participation in the SUS requires a set of planned and organized actions to defend this public good. To this end, advocacy actions based on coalition and building local networks' initiatives are legitimate to promote citizenship and greater effectiveness in PHC territorial management.

From this perspective, the experience of territorial health management of Teias Manguinhos is presented below, with its collective spaces of participatory management, in which it sought to repudiate the conception of society that those with education and resources point the 'correct' way for the working classes[21]. It is not by chance that the health unit – Family Clinic – inaugurated within the Teias in 2010 was named after Prof. Victor Valla, the author of this quote[21].

Context and reflections on Teias Manguinhos

A new PHC care and management model in Manguinhos was facilitated through a management contract established between the Municipal Health Secretariat of Rio de Janeiro (SMS-RJ) and the Sergio Arouca National School of Public Health, the Oswaldo Cruz Foundation (ENSP/FIOCRUZ) in October 2009, which occurred in a broader context of health changes conducted by the municipal management[22,23]. The primary mission of Teias was to expand access and quality of care in the territory, with a change in the care model centered on the ESF, according to national benchmarks[8,9]. The constitutional values of universality, comprehensiveness, equity, decentralization, and social participation in health motivated the management to adopt devices inspired by Carvalho[7] and ParticipaSUS[4].

One of the particularities of this context is that, besides the concept of network integration and health care, promotion, and prevention actions, Teias Manguinhos incorporated the components of the production of scientific and technological knowledge, teaching, and research related to the institutional mission of FIOCRUZ, a secular institution in the territory.

In a thematic excerpt of the experience, this essay addresses aspects related to participatory management, particularly the devices adopted in the territorial scope. We present reflections and actions experienced from December 2009 to May 2014, when the Teias implementation started. Therefore, narrating is assumed to enable the re-signification of events that point to strategies for social participation.

The information sources employed in this report were the authors' experiences, Management Collegiate members in that period, and the systematization of technical documents released and made public at the time, in leaflets and digital media, among other means. The ethical aspects of the reports are ensured with such data nature, emphasizing that the interpretations represent the authors' view.

Some historical background of the territory

Manguinhos was officially declared a district in 1981. It is located in the North Zone of Rio de Janeiro, in the city's 10th Administrative Region (RA), which also includes the districts

of Bonsucesso, Olaria, Ramos, and the Alemão and Maré Complexes. The district grew around FIOCRUZ, an institution created in May 1900. Since then, it has been active in the environment and with its residents, including social cooperation and health care actions. Before Teias, health services were offered at a PHC Unit (UBS – Germano Sinval Faria School Health Center) linked to the ENSP.

The creation of Teias expanded the coverage of the ESF to 100% of the population of Manguinhos at the end of the first year (October 2010), bringing a total of 37 thousand registered people (a similar number to the population of the 2010 census), which meant a significant achievement both for the increased offer of services and the provision of conditions for shifting from the traditional PHC model to an ESF model. To this end, another UBS (Victor Valla Family Clinic) was built, with 200 health workers recruited as Consolidated Labor Laws (CLT) workers divided into 13 ESF teams; five Oral Health teams; a Street Clinic team; a Family Health Support Center (NASF) and a Carioca Health Academy. Besides this service structure in Manguinhos, an Emergency Care Unit was inaugurated in 2010 and operated in close integration of flows with the UBS. All these devices have increased the resolutive capacity of care from the perspective of an integrated territory[8].

Manguinhos is a territory of significant economic and social vulnerability, one of the municipality's worst Human Development Indexes (HDI), with high violence rates. The area was chosen for the PAC in 2008, an intersectoral urban intervention that gathered the federal, state, and municipal governments. The official discourse was about integrating favelas into the formal city through urbanization and providing quality public services with an intersectoral approach, in which the health sector would have an effective participation[24]. Notably, in 2012, a Pacifying Police Unit was implemented, an initiative linked to public security to address violence in the territory, armed confrontations, and disputes involving drug trafficking.

Several changes in the environment and families' homes occurred during this period – this is a dynamic territory in geographic and social aspects[25] – which required efforts and flexibility for health management in the area, such as identifying local health problems and priorities, in planning, territorial team allocation, and the respective population records.

One of the local management's initial actions was collecting/analyzing data from the attendance records and indicators of the Health Information Systems to generate information and support decision-making. The systematization of such evidence revealed some characteristics of the territory, the families, and the people who inhabited it. Manguinhos was a district with declining births (birth rates), where men died prematurely from violence and the population aged rapidly, with a growing predominance of older adults against young people. Such demographic changes were reflected in the population's morbimortality profile, similar to the national setting, revealing the triple burden of disease: an unsurpassed agenda of infectious diseases (such as tuberculosis, syphilis, HIV, and dengue); a significant burden of external causes related to violence; and a significant presence of noncommunicable chronic conditions (such as hypertension, diabetes, cancer, and obesity).

This backdrop required new ways of organizing health services, especially those responsible for timely access, care throughout the life cycle, and resolving most health problems. It pointed out the importance of health promotion to encourage healthy living habits, mainly in the community dimension, for a healthy territory, which required implementing public policies to reduce health inequalities and foster social participation.

Paths to foster social participation

It was necessary to seek new strategies for intersectoral integration, especially with the institutions and sectors in the Manguinhos PAC, to address the complex context and build the bases for the participatory management of Teias. The performance in processes that sought mediation and consensual decision to legitimize partnerships and group projects was valued. The focus was on the shared production of knowledge and information to make each process an educational activity. As a result, the participation-management process aimed to produce goods or services and emerge as a powerful pedagogical space.

As of 2010, territorial health management was organized in a collegiate fashion (Teias-Manguinhos Collegiate Body), including unit managers and 'institutional supporters'[26], professionals who facilitate shared management in priority areas, such as information and health surveillance, education, communication, and health promotion. They fostered dialogue with the community and interacted with the work of community health workers, surveillance workers, and social agents, the territory's leadership that supported the social participation agenda. They worked in integration with the schools in the territory, from social assistance equipment to youth-targeted actions to work training spaces, the use of the Manguinhos Library, a space with multimedia resources, and several other health-promoting initiatives.

Local units' councils were established. They worked directly with the municipal Ombudspersons (program area 3.1) and FIOCRUZ to expand listening to the community, problem-solving, and user satisfaction.

In permanent contact with users and meetings with residents, health teams made this listening in their daily lives, but other possibilities of interaction were introduced. Besides a user satisfaction survey conducted at the units and homes, a digital evaluation system was installed at the UBS as another tool to improve the quality of services.

Institutional supporters, FIOCRUZ Social Cooperation, health teams, and local leaders prepared technical materials such as the newspaper 'Comunidade na Saúde', which presented information about Manguinhos, the organization of the ESF, and health indicators of the population used to promote 'reading cycles'. Intentional conversations between teams and residents held in different areas of the community occurred, which aimed to foster community empowerment, motivate leaders, and build local alliances. Problems and paths were pointed out in the debates, and the most frequently discussed topics referred to the environment and the PAC; local violence; the accumulation of garbage in the streets and rivers of the region; diseases resulting from this unhealthy environment; to the operation of the UBS – barriers to access to other services on the Network. A highlighted issue referred to mental health, the approach to alcohol and drugs, and the several scenes of drug use and homeless people in the community.

These meetings served as a basis for building a 'Mobilization Plan for residents, professionals, and managers' that guided the construction of conceptual and operational guidelines for a new territorial intersectoral participatory management body called the Intersectoral Management Council (CGI) of Manguinhos.

The CGI was recognized as a space for local decisions to agree, monitor, and inspect territorial management actions. However, it was not formally established in social control bodies of the SUS, such as the district council. The intersectoral composition was justified by the need for synergistic action with sectors of the Manguinhos PAC (federal government, state, and municipality) to provide greater care integration and, from the perspective of health-promoting policies, addressing the social determinants of health.

In October 2011, the CGI of Manguinhos was elected in a public assembly consisting of 48 councilors, with equal participation of the public power and the community, including the representation of the health sector, the education, and social assistance sectors. Intersectoriality was also present in the community representation, organized by social segments (*table 1*).

Table 1. Description of participatory strategies developed within the Teias-Manguinhos (2009-2013)

Participatory Management Strategies	Characteristics and Periodicity
Intersectoral Management Council of Manguinhos (n=48 directors)	Parity composition: 6 managers, 6 professionals, 12 councilors from civil society (n=24 members), and alternates (n=24) elected at the assembly, by social segments. Monthly meeting.
Teias Management Board Meetings	Deliberative group with unit managers, supporters, guests for planning, monitoring and management matters. Weekly or biweekly meetings.
Collegiate Manager of PHC Units	Deliberative group of the management of each unit (n=2), with representatives of workers, management, and users. Monthly meeting.
Family Health Team Meetings	Space for clinical and administrative discussion of the team and for continuing education. Weekly meeting.
Social participation local spaces	Conversation circles between teams and supporters with the community. Varied periodicity of meetings.
Spaces for group continuing education for Teias workers	Theme defined jointly. Varied periodicity of meetings.
Health Thematic Seminars	Expanded discussion of scientific and strategic topics, open to the general public. Varied periodicity of meetings.
Territorial Health Conference	First Manguinhos Conference, open to residents, held in auditorium/ENSP.
Ombudsperson of the Municipal Health Secretariat and FIOCRUZ	Space for collecting direct information from users, whose demands/needs were answered timely and in the most appropriate way possible.
Health Information, Education, and Communication Tools	Development of technical-technological production for the dissemination of knowledge.
	Booklet, folder, business card for the teams, video about the ESF in Manguinhos; health indicators panel; Portal: transparency, communication and participation, access to the ENSP website.

Source: Own elaboration.

An action conducted by the CGI in synergy with the movement of the Health Conferences held in 2011 was the Territorial Conference, with about 300 participants, including users and workers. Although this Conference was not formalized to elect municipal health councilors, the promotion of social participation was expressive, with ethical debates and the emergence of local leaders. Local health conferences are potential spaces for dialogue between health professionals and residents to select priorities in actions in a free, inclusive, and consensual way.

Some of the proposals approved at the Final Plenary were implemented in the short term and others in the medium term, such as the production of technical materials (video,

calendar, and folder) clarifying the work carried out by the ESF; the implementation of the 'Street Clinic' team and professionals with expertise in mental health and chronic diseases for the NASF; the movement for the installation of a traffic light on the road urbanized by the PAC; the expansion of a library managed by the state government; the organization of garbage collection and a petition of the residents, started in July 2012, and delivered to the municipal health secretary, for the construction of new mental health equipment, a Psychosocial Care Center in Manguinhos, an achievement realized in 2014.

From the perspective of public management by results, the management of Teias produced quarterly accountability reports with workers, informing and discussing the situation of management, access, assistance performance, and efficiency indicators agreed upon with the municipality. The production of these reports was intended to encourage the autonomy and commitment of health teams to the result of the work and to render accounts to the community in a movement called accountability.

Public management transparency and communication were priorities for the 'radicalization of participatory management'[7] to allow citizens to monitor the offer/use of services in the territory and public spending. The appreciation of technical reports, budget expenditures, and other managerial actions, and adopting other participatory management strategies were part of the debates with the CGI, which were systematized in *table 1*.

The concepts and practices reported in the experience of participatory management of Teias Manguinhos were anchored in the advocacy of citizen social participation in health. These actions fostered new ways of organizing the relationship between managers, professionals, and the population, building spaces for creativity and participation in producing health, despite the violence in that territory.

Final considerations

Implementing participatory health management practices in the territories strengthens the propositions of policies that promote health and reduce social inequalities. Democratic management and health practices can be developed through social technologies that value participatory management, shared between workers-users-managers, with the responsibility to identify and solve local problems associated with strategies to strengthen community mobilization. Moreover, it requires building a healthcare model that incorporates the essential and derived attributes of PHC, such as community orientation in the territories.

The participatory management at Teias em Manguinhos was organized per the references of citizen social participation to address the social determinants of the health-disease-care process, shared accountability, education, and communication, and the adoption of institutional support, which is intrinsically related to intersectoral action.

Teias Manguinhos intersectoral agenda was implemented as a tool for streamlining knowledge and skills and establishing synergistic relationships with local stakeholders and forces. The concept of intersectoriality is polysemic and can be understood as a new management rationale or as an intersectoral articulation political strategy[27] to build a sustainable and effective agenda for the country.

The implementation of this agenda, specially built from local stakeholders and institutions, brought enormous conceptual and operational challenges regarding sustainability in future settings since intersectoral action is permeated by conflicts and ideological disputes arising from different political and institutional conceptions.

Considering that healthcare systems must respond to local health needs, we concluded that the experience produced institutional spaces for listening and shared decision-making in Manguinhos, including the community and workers. The development of

social technologies, such as CGI, allowed the inclusion of people and social segments with greater independence to minimize the influence of particular and conflicting interests in the territory. Fostering social participation in this territory required continuous learning and mutual respect to establish a relationship of trust between management, workers, and users. Identifying local transforming agents, entities, and leaderships strengthened advocacy actions for social participation and public policies that promote equity, which involved changing health management paradigms with strategic action in the territory.

This experience presented memory and political action that legitimize the power of PHC in community strengthening, a possible radical utopia. However, dismantling several social policies resulting from neoliberal movements and their repercussions after 2017 in the country[28] is a cause for concern for people committed to the ideals of health reform. In the case of the health sector, particularly in PHC, this was evidenced by the change in regulations, restrictions, and public funding mode, threatening the universality of access to health[29].

Far from being a completed agenda, there are still new obstacles to be overcome in defense of a national and solidary development project aimed at reducing inequalities. May they be overcome – Antônio Ivo de Carvalho: present!

Collaborators

Engstrom EM (0000-0001-6149-3396)* contributed to all stages of article preparation, planning, manuscript writing, and text review. Silva VC (0000-0001-5364-3067)* contributed to the design and elaboration of the article at all stages. ■

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