Original articles

Primary care from perspective of public health managers: qualitative study

A atenção básica na perspectiva de gestores públicos do sistema único de saúde: estudo qualitativo

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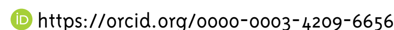
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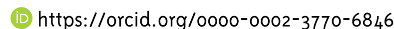
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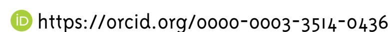
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Abstract

Primary Care refers to level of care that allows citizens to access the Brazilian National Health System (SUS) longitudinally and continuously. Proposal and operationalization of health management reaffirm social values, such as right to health. To qualitatively analyze perspectives related to this level of care, we interviewed managers from different hierarchical levels of Primary Care in a municipality of Mato Grosso. The data collected underwent a thematic Content Analysis, referenced by strategic thinking and planning in Public Health. Data concerning health management in Primary Care and the care provided to the population produced thematic nuclei involving rotational management, fragmented and emergency actions; opposition between humanization and technique; vertical health promotion. Managers showed commitment and search for the maintenance of services via assistance and specific actions. Top-down organization, which excludes user participation in planning, seems to have reinforced inconsistencies between the comprehensive proposal of Primary care and the daily structural unforeseen events, hindering the problematization necessary to transform the work processes. Institutionally strengthening the Primary Care network requires investment, permanent professional qualification, and active participation of subjects.

Keywords: Primary Health Care; Health Management; Strategic Planning.

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Resumo

A Atenção Básica (AB) refere-se ao nível de atenção que permite cidadãos(ãs) acessarem o Sistema Único de Saúde (SUS) longitudinal e continuadamente. A proposta e operacionalização da gestão em Saúde reafirmam valores sociais como o direito à saúde. Com o objetivo de analisar qualitativamente perspectivas relacionadas a este nível de atenção entrevistou-se gestores(as) de diferentes níveis hierárquicos da AB de um município de Mato Grosso. As informações produzidas foram submetidas à Análise de Conteúdo na modalidade temática, referenciada pelo pensamento e planejamento estratégicos em saúde, no âmbito da Saúde Coletiva. Os dados relativos à gestão em saúde na AB e ao atendimento à população produziram núcleos temáticos envolvendo gestão rotativa, atuação fragmentada e emergencial; oposição entre humanização e técnica; promoção *vertical* da saúde. Os(as) gestores(as) demonstraram compromisso e busca pela manutenção dos serviços por meio de ações assistenciais e pontuais. A organização *top-down*, na qual não está prevista a participação dos usuários(as) como condição para o planejamento, parece ter reforçado incoerências entre a proposta abrangente da AB e os diuturnos imprevistos estruturais, dificultando a problematização necessária à transformação dos processos de trabalho. Fortalecer institucionalmente a rede de AB exige investimento, qualificação profissional permanente e participação ativa dos sujeitos.

Palavras-chave: Atenção Básica em Saúde; Gestão em Saúde; Planejamento Estratégico.

Introduction

Primary Health Care (APS) in the Brazilian Unified Health System (SUS), called Basic Care (AB) refers to the first level of healthcare (Starfield, 2002). The expansion and consolidation of AB in the country began in the 1990s, initially with the Community Health Agents Program (PACS), in 1991, and with the Family Health Program (PSF), in 1994. In 2006, the National Primary Care Policy (PNAB) officially turned the PSF into the Family Health Strategy (ESF), a replacement model for reorganizing AB, with multiprofessional teams and activities developed with an attached population (Brazil, 2006a).

Melo et al. (2018) analyzed the two revisions which the PNAB underwent: one in 2011, which aimed to improve and qualify AB; and another in 2017, whose changes in relation to the previous edition were, among others, the withdrawal of the word **democratic** for care and management practices; and the word **humanization** for the principles of the PNAB. Furthermore, greater autonomy and flexibility were granted to municipal management, which has a key role in the operation and management of AB.

According to Starfield (2002), the main attributes of PHC are being **first contact** of the population with the healthcare network; **longitudinality** (or a longitudinal link of care), identifying the follow-up of users over time, with professional accountability and trust; **comprehensiveness**, which assumes the existence of a network of services at different levels of complexity and competencies, integrated actions in the different levels of healthcare to respond to the different needs of users. For the author, APS also requires **coordination of care** by means of records, clear and accurate information, and articulation between services. Primary Health Care also comprises **family approach** and **community focus**, defined by the **cultural competence** the professional working in AP, considering the subjects in their individual characteristics and socio-cultural background, beliefs, values, understanding of health and illness etc.

It should be noted that APS is not homogeneous, as it is organized in different fluxes in each country. Giovanella (2018) recalls that the AB idealized for Brazil after the Constitution of 1988

was not guided by a selective approach, with a focused and restricted set of services, but by a broadened and comprehensive concept of health consisting of essential components, brought by the historical Alma-Ata International Conference on Primary Health Care, held in 1978, involving **universal access and first point of contact** of the healthcare system; **inseparability** between health and socioeconomic development, recognizing the so-called Social Determinants of Health (SDH); and **social participation**.

In light of what was exposed above, it can be deduced that AB expresses a notoriously complex level of care, which demands that workers extrapolate techniques and procedures, even if those are essential. As far as management is concerned, it is an exercise of power inseparable from the political issues involved, as pointed out by Campos and Onocko-Campos (2008), notably through corporate orientation of the SUS toward universal access and comprehensive care.

In an integrative review, Pires et al. (2019) searched for studies on AB management produced between 2006 and 2016 and identified that the topic was addressed in national and international scientific articles by aspects related to health policy and the challenges of management practice. Among the gaps, the lack of investigations that conceptually expand AB management. The authors reaffirmed the relevance of the subject for the health sector and stressed that the definition of policies and health action would be mediated by management in coordinating collective work and providing environments for work practice. They also ratified the direct impact of management on health services.

The sanitation authority, which emerged in the early decades of the twentieth century, was the precursor of the current AB system (Campos, 2007). With normative, hygiene-oriented and centralizing characteristics, it proved insufficient to provide the organization of AB following the parameters of the SUS and its political guidelines of participation, social control of managers by civil society, co-management and democratization of access to health as a social right guaranteed by the Constitution.

In this direction, Guizardi and Cavalcanti (2010) advocate the idea that it is necessary not just to improve the SUS, but also to understand it as a field of production of new subjectivities to revolutionize life. Furthermore, the authors warn that health management is not limited to strictly technical, normative acts; nor is it exclusive to managers. For the authors, management involves an action that is normative by definition, and therein lies its political dimension, but it could never be isolated from the network of implications in which human relations are interwoven.

Therefore, in addition to the written word of legal regulation, Bousquat et al. (2017) investigated the perspectives of AB users and managers. The results produced suggested significant differences. While managers recognized AB as the gateway to the Healthcare Network (RAS),[1] though being aware of the challenges to its effective implementation, such as the mechanisms of information continuity, users did not consider it either as a gateway or a regular place for delivery of care, nor did they perceive it as a space for clinical treatment. Studies of this nature warn of the need for research focused on the perspective of those involved in AB, whether they are users or managers, under the risk of overlooking elements that give meaning to management and health experiences.

The field of collective health and its classic tripod, represented by the social sciences and humanities in health – policy, planning and management, and epidemiology – recognizes the importance of studies and practices that, by extrapolating technical and normative issues, protocols and information systems, acknowledge the role of subjectivity in organizational management and intersubjective aspects that often make up the planning and strategic actions developed (Rivera; Artmann, 2019).

Considering the strategic thinking and planning in collective health, whose formulations aim to break with the normativity of a duty imposed on reality to transform power configurations (Matus, 1993; Testa, 2020), the different perspectives related to AB, in addition to the need for the implementation of health policies to also be guided by *bottom-up* approaches

1 The healthcare network is defined as organizational arrangements of health actions and services of different technological densities, integrated by technical, logistical and management support systems, which seek to ensure the full provision of care (Brazil, 2010, p.4).

to health, the focus of which is on the subsystems of public policies and on the strategies of those involved (Lima; D'ascenzi, 2013), we conducted a field survey with managers of a town in Mato Grosso State with the objective of understanding in what terms their action in AB takes place. We expect that the data produced will encourage transformations and improvements in the topic, which is still little explored qualitatively. We sought to answer the question: How do AB managers analyze this level of care, including health management and provision of care to the population?

It should be clarified that Basic Operational Standard 96 (Brazil, 1996, p.8) distinguished the terms **management** and **administration**: the former concerns the "responsibility of running a health system (municipal, state or national)", and the latter the "administration of a healthcare facility or organization". However, to meet the objective of analyzing the perspectives of AB by those involved in running it, either in the administration of healthcare facilities or at central level, all the interviewees were named managers.

Methodological path

This is a qualitative, descriptive-exploratory study, conducted in a town in Mato Grosso State, in Brazil's Midwest. The setting for the study is basic care (AB). We listed as possible participants in the study managers working at different levels of hierarchy. Although this diversity expresses different degrees of decision-making power amongst the interviewees, the lack of distinction is justified in that all of them participate in the same public healthcare network, with intersubjective resonance among them in the composition of the town's AB. According to Minayo (2017), the relationships between people suggest interdependence, therefore interviewing the representative of a specific group produces a testimony which is both personal and collective at the same time.

The following research techniques and instruments were used: observation, recorded in the research journal; semi-structured interviews, recorded and transcribed entirely using the Microsoft Word *software* for subsequent processing by thematic content analysis, in Minayo's terms (2014). The interview script was prepared with questions guided by two axes: a) set of health management ideas, particularly AB; and B) provision of care for the population in AB.

Observation took place by direct and face-to-face contact with managers in their workplaces, for a period exceeding the time allocated to the interview. The objective was to create a stronger bond between the observed subjects and the researcher and to produce information that would remain invisible by other means (Minayo, 2014). This meant monitoring the professional relationships in the workplace, routine flows to meet the demands, prioritization of institutional responses, among other aspects of the daily lives of the interviewed managers.

After the interviews, we used the following sequence for the proposed analysis: (1) pre-analysis: after the transcriptions were made, we proceeded to approach the content of interviews and records in the research journal; (2) exploration of the material: we tried to understand the contents produced for the elaboration of the thematic nuclei, re-reading the transcribed material, the research journal and re-listening to the audios; (3) treatment of the results produced, associating the thematic nuclei with the theoretical references.

Regarding ethical aspects, it is worth highlighting that the research is part of the project *Governança, Regiões e Redes em Mato Grosso, connected to the national multicenter study Política, Planejamento e Gestão das Regiões e Redes de Atenção à Saúde no Brasil, approved in the public notice MCTI/CNPq/CTSaúde/MS/SCTIE/Decit Nº 41/2013.*, approved by the Research Ethics Committee (CEP SAÚDE UFMT) through Opinion No. 2437262, in compliance with the ethical precepts of Resolution No. 466/2012, of the National Health Council (CNS).

The project requested the collaboration of the Health Department of the selected town in Mato Grosso State, as duly registered in the terms of consent to the research.

Results and discussion

In the last quarter of 2019, we interviewed ten AB managers of the selected town; eight of them

had a nursing degree; one had a psychology degree; one had a nutrition degree; eight were specialists, none had specific (*lato* or *stricto sensu*) training in management; only four were statutory civil servants; six had served in management positions for more than five years, but on a rotating basis, in the town's healthcare network.

To conclude the interviews, we observed the volume and quality criteria, defined by the recurrence and complementarity of the information (Minayo, 2017).

The analysis of the data resulted in five thematic nuclei: (1) turnover in AB management; (2) fragmentation of actions; (3) emergency in performance; (4) opposition between humanization and technique, and (5) vertical health promotion, as described in Chart 1.

Chart 1 – Axes of analysis and thematic nuclei based on the interviews and observation

Axis of analysis	Thematic nuclei
Health Management in AB	Management turnover
	Fragmentation of actions
	Emergency in action
Population care	Opposition between humanization and technique
	Vertical health promotion

Management turnover referred to the change in the role of the interviewed manager or of the central level, which undermined the work process and hindered the critical analysis and monitoring of the results achieved, either to improve or to meet the health demands of the population in a territorialized and timely manner. "*And what happens here today in management, as we have a lot of personnel turnover, it is very difficult to manage* [...] *I am in charge of the special programs, but in some, if the manager changes, everything changes. If the Secretary changes* [...] *But we try to make it run smoothly*" (Manager 5).

We found that mostly specific actions were developed in this rotating context, based on providing care for unforeseen events in each Primary Healthcare Facility (UBS) or AB sector at the central administrative level. These situations partly led to planning not being the priority, with several centers of care lacking coordination among themselves.

The thematic nucleus involving **fragmentation of actions** was elaborated based on managers' recurrent mention of specific practices, for example, those focused on specific procedures, such as preventive cervical cancer screening (CCS) and vaccination campaigns. We also observed that they mentioned isolated practices developed at the UBS without articulation with other points of the RAS. Lack of intersectoral articulation in campaigns, programs and procedures did not generate a smaller workload, but seemed to point to a decreased comprehensiveness of healthcare. The performance reported mostly by managers was guided by indicators, ministerial programs, care pathways, references and counter-references in meeting the demands with specific, isolated and unarticulated practices. "*We constantly look at our indicators here. We look at the number of CCS... is it low? If so, what are we going to do? A task force on Saturdays?* [...] *the vaccination campaign, children are not coming to get vaccinated, many vaccination records are behind, are we opening on Saturday?*" (Manager 5).

We understand that AB, as part of the RAS, has to act in a network format, that is, with the largest coverage, effectiveness and diversity possible to meet health demands. It is not a question of neglecting specific procedures, but of warning of their key importance in a context where there are legal provisions for the coverage and articulation of actions such as AB, as defined by Ordinance 4.279/2010 (Brazil, 2010) and by Decree 7.508/2011 (Brazil, 2011). "*In many cases, in many situations, our APS does not organize the network, in my perception we do not function as a network yet. The lack of care pathways is a problem, right?*" (Manager 4).

The urgent nature of the daily actions, as reported by the managers, composes the following nucleus, whose content translated the **formula for management and planning in AB**, adopting as the guiding concept of formula the one brought by Alice Krieg-Planque (2010), which refers to a kind of unforeseen *slogan*, which arises in the course of the study and synthesizes various elements of the

contents produced in the research, with the goal of condensing a certain collective message. Among its elements, the **relatively crystallized character**, "common place for debate, as a shared signifier" (Krieg-Planque, 2010, p. 74); a **discursive dimension**, without necessarily having a literal meaning, but always an oriented one; the **social reference**, which can be understood by many at a given time; and finally, **its controversial aspect, related to different degrees** to the social and political issues that it evokes. It should be noted that the formula is not something determined before the research process; it arises in the course of the investigation. The formula may not even be literally present in a production of results, and it may not emerge directly from narratives or discourses.[2]

We found among managers the *fire extinguisher* formula, associated with lack of control, dangerous situations, despair, impulsive and reactive action, an idea that the interviewees associated with actions developed in health management in AB. In the analysis of the formula, we identified the predominance of the controversial aspect, depicting a situation intensely related to the social and political issues of AB management in the town, such as management turnover in the sector (discussed in the previous thematic nucleus), administrative problems involving unplanned actions and transfer of funds.

The formula in question seems to refer both to the justification of non-planning and non-execution of actions occasionally planned, and to the impediments to the planning and execution of the corresponding actions. Thus, **fire-extinguishing** seemed as much to protect and justify as to condemn the manager.

The interviews and the observation showed situations of anxiety, distress, rapid and punctual responses of managers in daily health management. They listed problems and risks related to the **fire-extinguisher** formula. They were represented by the results caused by the lack of strategic planning that allowed the exercise of coordinated and articulated actions at other levels of care. According to the managers, when there was planning, it seemed to subsume the next unforeseen event.

According to the interviewees,

> *We are managing, I usually say, we put out fires there and plan here. (Manager 4)*

> *So, these are things that we are trying to change, but it is very complex. Things are dynamic here, and because the SUS has a sort of complicated past, it is part of our daily routine to put out fires. So, you have to plan and put out fires, plan and put out fires. It is a complicated situation.* (Manager 2)

In this direction, recalling fundamentals of strategic health thinking and planning, in the terms of Testa (2020) and Matus (1993), becomes relevant in order to materialize changes recognized as necessary by managers and legitimized by the population. For Testa (2020), to think about health is to recognize the social determination of its practices, in which management is included as a political action guided by the established power relations and the ideology that underpins them; expressing values and beliefs that affect the subjects' understanding of the world. This means asserting that **thinking about health** implies a reflexive stance, with enough time and space for the maturation of proposals and for the recognition and analysis of the health situation that managers find.

The strategic planning of Matus (1993) refers to a complex, dynamic and continuous process that **precedes and presides over the action**, surrounded by multiple actors who interact in the social reality that conditions them in varying degrees of governability. The author argues that it is essential to identify, describe and analyze the set of problems that emerge from a situation under analysis by addressing them in four distinct moments: explanatory, with analyses to identify the problems of the initial situation; normative, deciding whether such operations will be executed to address the problems identified,

2 We considered that the notion of *formula* – although commonly in connection to the field of French-inspired discourse analysis – could contribute to the proposed thematic analysis by organizing and synthesizing elements of both the interviews and the records of the observations made.

considering the political timing of the situation-object; strategic, in which the viability of the proposed strategies and operations is identified; and tactical-operational, in which time management must be executed, monitored and evaluated.

It should be noted that **moments are not sequential steps** since they are actually developed simultaneously and in an integrated manner, and one moment may predominate over the other (Rivera; Artmann, 2019). The **fire-extinguisher** formula makes it difficult to **think for action**, a central aspect of the theoretical elaborations of Testa (2020) and Matus (1993).

In the state of affairs in which the managers found themselves, problems included structural issues and shortage of workforce. The managers pointed out structural difficulties and lack of resources as impediments to higher quality in AB. Improving work processes, care pathways and articulation of the RAS requires sufficient structures[3] to meet the demands of the UBS. The analysis of this issue alludes to the history of underfunding of the SUS (Ugá et al., 2012) and renews the ever-present need to fight for structural advances as an essential and inseparable condition of the right to health in the country.

The **fire-extinguisher** formula also condensed elements of the performance of the managers interviewed in AB, highlighting the apparent impossibility of putting health planning into effect when it is performed *pro forma*. Its controversial character results from that fact, because according to the theoretical framework adopted, planning precedes and presides over action, it is not developed in sequential steps and does not refer only to an evaluative stage. As a result, it is necessary to denaturalize the notion of **fire** in health action. Though it sounds heroic and is often expected with regard to institutional problems, it justifies emergency actions that misrepresent organized and strategically planned health work, making it difficult to recognize the power relations in the sector and the work itself in the conformation of the social being. In other words, **fire-extinguishing** seems to erase the role of managers, in their own perception, in the structure and model of health care.

The **opposition between the use of relational technologies**, involving communication, listening, empathy and humane reception (Coelho; Jorge, 2009) and **the technical application of procedures**, as soft-hard and hard technologies, in the terms of Merhy (2002), expressed the thematic nucleus that highlighted the misguided **opposition between humanization and technique in AB** from the perspective of managers. In the following interviews, this opposition can be clearly noted:

> *Because technique, if you want to work in a hospital, you have to have very good technique for procedures, right? If you have good technique for procedures to take care of patients, you have potential. But, not in AB. You need heart in AB!* (Manager 1)

> [...] *we struggle at least with humanization every day because patients often do not have any disease, but, they come in, sit down and talk, I am always very emphatic about that. aThat if they come in, just saying good morning is enough for them to leave. You don´t even have to give them a prescription. They will leave happy.* (Manager 2)

Such discourses help to strengthen the biomedical model at other levels of healthcare, creating inconsistencies in the comprehensive proposal of AB and in the full-coverage actions that support it as a method to put it into effect, in the terms of Testa (2020).

Care is diverted, the body and its biological responses are isolated by minimizing their importance for the user's health.

As a counterargument to the previous considerations, the lack of humane, active and qualified listening can also hinder dialogue with users in the construction of possible and alternative pathways, including pathways beyond the health sector. Therefore, we should bear in mind that humane treatment does not mean excluding any health interventions.

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3 Structure was considered to be labor force, inputs, physical structure and various technologies.

In the field of public health, the transversal concept of humanization carries the idea of transforming the models of care and management, with the necessary quality and ability to promote encounters and interactions between users and workers, both protagonists and co-responsible for universal access, comprehensive care and equal provision of health (Campos, 2012).

However, inspired by the original considerations of the Lefevre couple (2004), this does not mean excluding the negativity of illness from AB, but to understand it as a signifier, or interpreter, of what does not go well in the user's life, so that they can search for something better, in a broad sense and always in a transient way. For Campos (2012), devaluing the clinic in health production means reducing the complexity of the health-illness process, at any level of care in the public health system.

The elaboration of the last thematic nucleus was guided by an apparent contradiction between terms when health promotion and vertical actions are associated in the managers' accounts. Named **vertical health promotion**, this nucleus brought to the forefront an aspect of health promotion that is not always recognized, namely the standardization and imposition of *best practices* related practices in health, commonly guided by epidemiological notions of risk that fail to encompass the complexity of the process (Czeresnia, 2020).

The elements identified in the interviews, associated to health promotion by the managers, to compose this nucleus involve achieving the goals of the ministerial programs, as recommended in the planning instruments; focusing on the disease with actions aimed at signals and symptoms; referring to Integrative and Complementary Health Practices (PICS); walking groups; reiki groups; active search for CCS; updating vaccination records; administration of deworming and pediculosis medicine. We found that there was no distinction between health promotion and prevention.

Although health promotion is represented in the *Health Pact*, specifically in the operational guideline presented by the component *Pact for Life* (Brazil, 2006b), for actions involving incentives to physical exercise and healthy eating habits, control of smoking, control of alcohol abuse and special care in the aging process, connected to the understanding of health as a human right and a citizen's right, we should recall the considerations of Czeresnia (2020). According to the author, prevention is defined as interventions aimed at preventing the emergence of certain diseases, seeking to reduce their incidence and prevalence in populations, following epidemiological knowledge.

Health promotion, in turn, is related to measures that utilize scientific knowledge (as is the case in disease prevention) to strengthen the individual and collective ability to cope with the multiple health conditioning factors (Czeresnia, 2020), considering the participation and concrete options of those involved, their subjectivities, values, autonomy and differences produced in daily life.

In the study we conducted, the low participation of people and the precarious collective construction of public health policies were grouped as vertical health promotion, given its prescriptive and pre-oriented character; in other words, as expressions of a *top-down* approach to public health policy management (Lima; d'ascenzi, 2013), which could be translated as a **must be**.

This imposition seems both to compromise the legitimacy of the actions developed by the manager and to misrepresent health promotion as an exercise of citizenship that goes beyond the institutionalized modes of social control. Managers also mentioned annual *pro forma* plans as protocol actions which are not fully incorporated and ratified the low engagement of organized groups and social movements in the process of designing and implementing the town's public health policy. This process was undertaken away from citizen engagement, which is an essential element of health promotion.

According to Campos (2012), some approaches to health promotion tend to underestimate social conflicts and macro political factors in the genealogy of sanitary conditions, in addition to acknowledging specific modifications, without changes in the *status quo;* and without emphasizing the strategic importance of public health systems, which have a great impact on the expectation and quality of life of the population.

On the other hand, Buss et al. (2020) stated more recently that health promotion can represent a

promising strategy for coping with health problems which affect the population when it is guided by the articulation between technical and popular knowledge, mobilization of institutional and community resources, both public and private, to promote quality of life. The authors recalled proposals of nineteenth-century sanitarians, such as Villermé in France; Chadwick in England; Virchow and Neumann in Germany, for whom the causes of epidemics were as much social and economic as they were physical; and the remedies for them were prosperity, education and freedom. Today, they highlighted the movement of healthy towns, intersectoral actions, the inclusion of health in all policies and the confrontation of Social Determinants of Health (SDOH) with health promotion actions related to public management innovations for integrated, sustainable local development.

However, in both positions social participation can be made invisible by unilateral prescription, either when it refers to changes in society and in the *status quo* of preconceived forms, or when undertaking health promotion actions that fail to acknowledge the *other* in the process. Therefore, as Heidemann et al. (2014) state, health promotion is a comprehensive concept and putting it into effect requires intersectoral articulation – and essentially involves the relationship with people.

Final considerations

According to the theoretical approach adopted, strategic thinking and planning of health means considering proposals that materialize the social right to health in different degrees, ratifying its eminently public character and the values related to social participation, without which health policies lose their purpose of meeting collective human needs under which they are based, and which should guide them.

The study conducted with the town's public managers reaffirmed the complexity of AB and health management at this level of care. We found that the performance of the managers interviewed reflected dialectically the organization of the health system, extrapolating the merely volitional direction[4] of their actions.

We observed that the managers perceived AB as a level of attention that requires full commitment and dedication, but it does not offer many possibilities for strategic planning due to the many demands resulting from deficiencies in the structure of the UBS and integrated access to the RAS. In addition, managers seem to associate working in AB with humanizing actions that exclude the need for greater resolution of illness, as if the personal bond could somehow replace it at this level of healthcare.

In this logic, other levels of care would be responsible for taking care of the symptoms exhibited by users. Primary care would be in charge of disease prevention in the form of actions established by ministerial programs and specific campaigns. We highlight the health promotion actions, also mentioned by the managers as members of AB. Nevertheless, they are expressed vertically, which creates a contradiction between terms if health promotion is understood in its intersectoral and participatory character.

The research suggests the need for greater qualification for AB management, creation of spaces that strengthen communication and interaction in the RAS, and inclusion of users as active citizens capable of responding for what affects them and for what they are directly involved in within the scope of health services.

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Authors' contribution

Nicolau and Faria conceived and designed the study, analyzed and interpreted the data and wrote the final version of the article. Palos reviewed and approved the version for publication.

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