Convergences between primary health care planning and the Sustainable Development Goals: an evaluation of municipal health plans in Brazil and Chile

Convergências entre planejamento de atenção primária à saúde e os Objetivos de Desenvolvimento Sustentável: uma avaliação de planos municipais de saúde do Brasil e Chile

Elizabeth Salinas Rebolledo[a]
https://orcid.org/0000-0001-9770-7392
Email: elisalinasr@gmail.com

Leandro Luiz Giatti[a]
https://orcid.org/0000-0003-1154-6503
Email: lgiatti@usp.br

[a]Universidade de São Paulo. Faculdade de Saúde Pública. Departamento de Saúde Ambiental. São Paulo, SP, Brasil.

Abstract

This study addresses the importance of Primary Health Care (PHC) to achieve the Sustainable Development Goals (SDGs), assessing convergences between two municipal PHC agendas and the 2030 Global Agenda. For this purpose, the PHC actions included in the municipal health plans of Santiago, Chile, and São Paulo, Brazil, were evaluated by content analysis. Results showed that the PHC actions planned in Santiago contributed to 14 SDGs while in São Paulo, the actions contributed to the entire 2030 Agenda, although both plans lacked references to the SDGs. Thus, the PHC actions provided in municipal agendas are essential to achieve the SDGs. However, this relationship is not adequately reported, which can compromise the investment of greater resources in this sector. Therefore, a greater alignment between local, national, and global action plans and policies is required, as well as integrated and continuous training for communities and health teams and a greater use and diffusion of technologies already available in regional and intersectoral approaches to municipal health plans.

Keywords: Primary Health Care; Sustainable Development; Health Policy, Planning, and Management; Intersectoral Collaboration.

Correspondence
Elizabeth Salinas Rebolledo
Av. Jurema, 947, Guarulhos, SP, Brazil. CEP 07244-000.

Resumo

O objetivo deste estudo é explorar a importância da Atenção Primária à Saúde (APS) para a consecução dos Objetivos de Desenvolvimento Sustentável (ODS), avaliando as convergências entre duas agendas municipais de APS e a Agenda global 2030. Para tanto, utilizou-se a técnica de análise de conteúdo nas ações de APS previstas nos planos municipais de saúde dos municípios de Santiago do Chile e São Paulo, Brasil. A análise de conteúdo de ambos os planos mostrou que as ações previstas pela APS de Santiago contribuíam com 14 ODS, enquanto em São Paulo foram identificadas ações que contribuíam com a totalidade da Agenda 2030, ainda quando em ambos os planos houve algumas faltas de referência aos ODS. Conclui-se que as ações previstas pela APS em um nível municipal demostram ser essenciais à consecução dos ODS. Porém, esta relação não é informada adequadamente, o que pode comprometer a injeção de maiores incentivos neste setor. Logo, se requer maior alinhamento dos planos e políticas locais, nacionais e globais de ação, uma formação integrada e continuada nas comunidades e para as equipes de saúde, e maior uso e difusão de tecnologias já disponibilizadas em abordagem territorial e intersetorial dos planos municipais de saúde.

Palavras-chave: Atenção Primária à Saúde; Desenvolvimento Sustentável; Políticas, Planejamento e Administração em Saúde; Colaboração Intersetorial.

Introduction

The Sustainable Development Goals (SDGs) are commitments made in September 2015 by the 193 Member States of the United Nations (UN) that aim to eradicate poverty by 2030 and universally promote economic prosperity, social development, and environmental protection in order to improve the life of the world's population now and in the future (UN, 2015).

For the achievement of the SDGs, Primary Health Care (PHC) is the best way to ensure sustainable improvements in health, society, and the environment when supported by strong public policies and with their efforts aligned with the economic, political, and social domains (WHO, 2007; Pettigrew et al., 2015), as, since its development in 1978, it is the essential health care available to all individuals and families in the community, based on the principles of universal access, equity, and social justice—a commitment that was recently renewed in the Declaration of Astana in October 2018 (WHO, 2018).

The existence of a PHC-based health system is urgent, as, in the near future, more than 60% of the world's population will live in urban areas, which will cause a greater concentration of groups exposed to the possible effects of crises associated with the global phenomenon of unsustainability. Climate change and the effects of climate variability, food insecurity, reduced availability of water resources, increased poverty, inequality, lack of urban planning, illegal settlements, restriction of essential services, mental health problems, and contamination of environmental systems are some examples of them, and the most affected are the most vulnerable groups (PAHO, 2013).

Although PHC seems to be cross-sectional and congruent in the fulfillment of several SDGs, its role is not directly referred neither in the 2030 Agenda nor in SDG 3 (good health and well-being)—its specificity. Therefore, many governments still have difficulty in investing to reach the full potential of PHC (Pettigrew et al., 2015).

Recognizing a territory according to the logic of the relationships between living conditions, environment, and access to health actions and

services is the starting point to prepare these services to identify vulnerabilities, exposed populations, and the selection of priority problems for interventions (Gondim et al., 2008). A territory is where the very principles of the SDGs, such as those focused on reducing inequities and overlaps of risk factors, are put into practice. However, some difficulties persist when incorporating multi-territoriality in work practice and information systems, which impairs the intersectorality of health actions (Pereira; Barcellos, 2006; D'Andréa et al., 2010; Salinas Rebolledo; Chiaravalloti Neto; Giatti, 2018). Political and technical health agendas lack the debate on sustainable development and did not effectively include environmental health, sustainability, and social participation and control in the sector governance (Buss et al., 2012). Moreover, some PHC professionals still do not know the existence of relationships between health and the environment (Andrade et al., 2013).

Renewing PHC requires a critical analysis of its meaning and purpose (OPAS, 2008). Thus, this study addressed the importance of Primary Health Care to achieve the Sustainable Development Goals, assessing the possible convergences between two municipal PHC agendas and the 2030 Agenda for Sustainable Development, aiming to support the development of public policies, investments, and the use of technologies that encourage an effective community, territorial, and intersectoral work of PHC to substantially contribute to the achievement of the SDGs. This study also aimed to show diverse alternatives and convergences between PHC planning and sustainable development, which can support the replicability of promising actions in this context.

Methods

A content analysis was conducted to identify the elements or convergences of the SDGs in PHC actions provided in the health plans of two different municipalities: Santiago, Chile, and São Paulo, Brazil.

The commune of Santiago is located in the city center. It has an approximate area of 22.4 km², a population of 404,495 inhabitants, and mixed neighborhoods, where housing coexists with government, business, and service activities (INE, 2018). The Municipal Department of Health is responsible for PHC services, specialized mental health care, and emergency care and have a total registered population of 117,137 inhabitants (Santiago, 2018).

The municipality of São Paulo is much larger than Santiago and has an estimated population of 11,811,516 inhabitants in an area of 1,521.11 km². It is the most populous city on the American continent and the main financial, corporate, and commercial center of South America[1]. Its Municipal Health Department is responsible for PHC services and also has commitments at the secondary and tertiary levels, health surveillance actions, care for the environment, culture, and citizen peace. It manages 488 Basic Health Units[2] and 4,553,606 inhabitants are registered in the Family Health Program[3].

Data were collected in November and December 2018, under an adaptation of the content analysis techniques proposed by Bardin (2011). In the pre-analysis phase, an initial reading of the 2030 Agenda, the Health Plans of the aforementioned municipalities, and other documents mentioned within these plans was performed. The 2030 Agenda (UN, 2015), the Santiago Health Plan 2018-2021 (Santiago, 2018), and the Santiago Communal Development Plan 2014-2020 (Santiago, 2014) were the documents selected to constitute the corpus. In the case of São Paulo, the Municipal Health Plan 2018-2021 (São Paulo, 2018a) and the São Paulo Goals Program 2017-2020 (São Paulo, 2017) were selected. All municipal documents presented an

1 Information about the municipality of São Paulo were taken from the SEADE Foundation (Statewise System for Data Analysis Foundation). *Perfil dos Municípios Paulistas*. Disponível em: < http://perfil.seade.gov.br/ >. Acesso em: 2 set. 2019.

2 CNES data taken from:< https://cnes.datasus.gov.br/ >. Acesso em: 2 set. 2019.

3 The family registration in the São Paulo Primary Health Care Information System in 2015 is available at: < http://tabnet.datasus.gov.br/cgi/deftohtm.exe?siab/cnv/SIABFSP.def >Acesso em: 2 set. 2019.

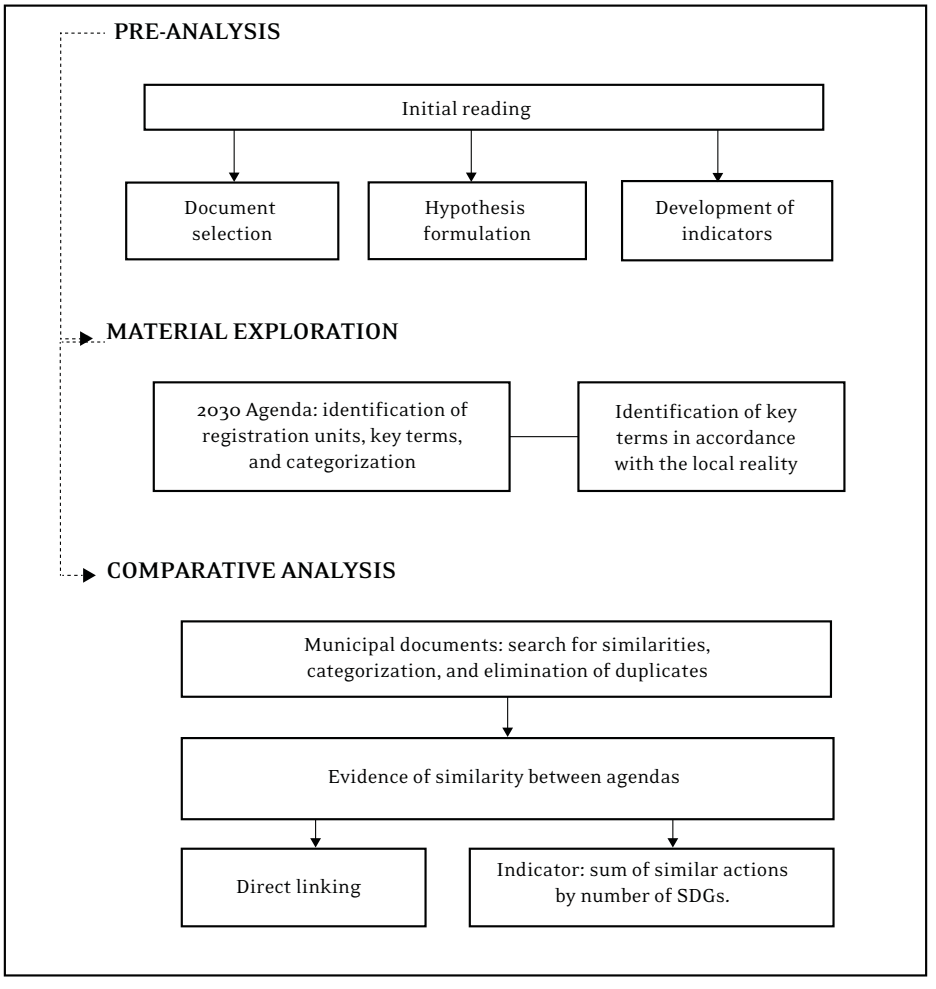
action program that went beyond PHC, therefore, only those actions under the responsibility of primary care or primary care along with other levels or sectors were studied.

The hypothesis was that the municipal health plans included PHC activities convergent with the 2030 Agenda, even if this relationship was not directly referred.

For the material exploration, the 2030 Agenda was used as a guiding document and all registration units were selected from this document. Therefore, the registration units met the 169 SDG targets to which their key terms were associated and, moreover, "Sustainable Development," "2030 Agenda," and other terms related to the local reality were added. The key terms "ethnicity," "discrimination," "Black," and "Mapuche" (Native Chilean group) were added to SDG 10 and "participation" and "territory" were added to SDG 11. The categories of analysis corresponded to the very SDG number in which the target is included.

Comparative analysis included the search for key terms in municipal documents. First, the terms "Sustainable Development" and "2030 Agenda" were searched—their presence would be a direct proof of the link between both agendas. Other key terms were found and, when they corresponded to similar actions or contributed to an SDG target, they were categorized according to the respective SGD number. Finally, duplicate content was eliminated and the sum of similar actions, categorized by the number, was presented as evidence of the relationship between PHC goals and the SDGs. Figure 1 shows a summary of the methodological process.

Figure 1. Summary of the methodological process



Results

Chart 1 shows the key terms identified within each set of goals associated with the SDGs.

Chart 1 – Key terms associated with each SDG

SDG No.	Key terms
1. No poverty	Poverty, vulnerability, income, admission, socioeconomic status, homeless population.
2. Zero hunger	Hunger, food, nutrition, agriculture, cultivation, vegetable garden.
3. Good health and well-being	Mortality, pregnant, pregnancy, child, AIDS, HIV, tuberculosis, malaria, disease, diabetes, hypertension, cancer, health, well-being, self-care, promotion, prevention, drug, alcohol, accident, universal access and coverage, quality, medicine, vaccine, tobacco, recruitment, health professionals, worker, risk, disaster.
4. Quality education	Education, school, student.
5. Gender equality	Woman, girl, gender, discrimination, violence, sexual and reproductive health, equal rights, empowerment.
6. Clean water and sanitation	Water, sanitation, hygiene, toilet, sewage, water reuse.
7. Affordable and clean energy	Energy, efficiency, fuel, light, electricity, gas.
8. Decent work and economic growth	Employment, work, economic growth, tourism and sustainable economy, productivity, innovation, entrepreneurship, creativity, business, training, occupational safety, banking.
9. Industry, innovation and infrastructure	Infrastructure, access, industry, innovation, technology, research, Internet.
10. Reduced inequalities	Equality, inclusion, migration, racism, discrimination, ethnicity, native people, Black, Mapuche, interculturality.
11. Sustainable cities and communities	Housing, urbanization, transportation, accessibility, settlements, heritage, resources, disaster, resilience, air, waste, public space, regional planning, participation, territory.
12. Responsible consumption and production	Production, consumption, management, waste, residue, recycling, sustainability.
13. Climate action	Climate, catastrophe, disaster.
14. Life below water	Ocean, sea, coast, fishing, fish.
15. Life on land	Ecosystem, forest, deforestation, degradation, desertification, biodiversity, habitat, flora, fauna, species.
16. Peace, justice and strong institutions	Peace, justice, violence, exploitation and trafficking of children, crime, terrorism, corruption, transparency, information, participation.
17. Partnerships for the goals	Partnerships, intersector, network, data, information, monitoring, public accounts.

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In the Santiago Health Plan (PMS-S), no text presented a direct reference to the term "Sustainable Development" or the 2030 Agenda. However, the Communal Development Plan presented a municipal healthy lifestyle policy called *Santiago Vive Sano*, which includes the program of

intersectoral activities for sustainable development (Santiago, 2014).

In turn, São Paulo Law No. 16,817 of February 2, 2018 (São Paulo, 2018b) adopted the 2030 Agenda as a guideline for municipal public policies. Therefore, the São Paulo Municipal Health Plan (PMS-SP) clarified this common orientation between both agendas, referring to SDGs 2, 3, 5, and 12 within the text. Moreover, the São Paulo Goals Program showed that the health sector contributes to the achievement of SDGs 3, 5, and 10.

Chart 1 showed that the actions provided in the PMS-S were related to 14 SDGs while in the PMS-SP, the actions addressed all the SDGs. Graph 1 shows the distribution of those actions for each municipality, their priority related to compliance with SDG 3, and the important participation of both municipalities with at least ten actions that contribute to SDGs 2, 5, 9, 10, and 16.

Chart 2 presents a summary of PHC actions in each municipality and for each SDG.

Graph 1 – Number of planned PHC actions classified by SDG, according to the municipality

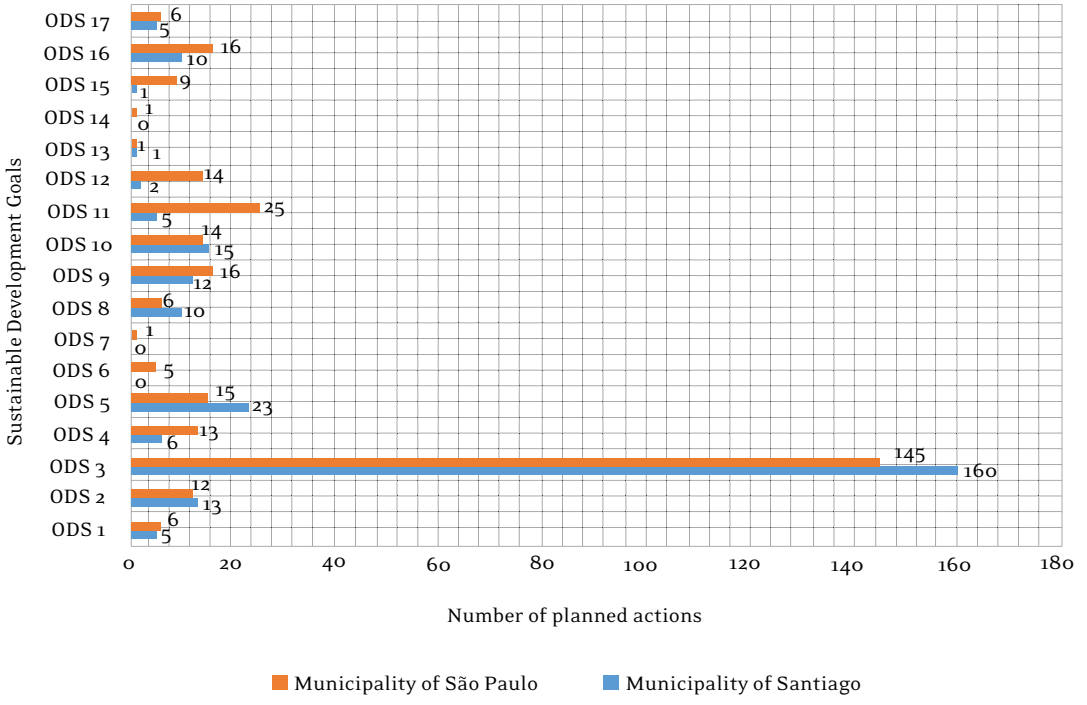

Chart 2 – Type of PHC action related to each SDG, according to the municipality

SDG No.	Santiago	São Paulo
1. Ending poverty in all its forms, everywhere.	Embracement and referral of the most vulnerable groups to intervention.	Embracement and referral of the most vulnerable groups and homeless people to intervention. Participation of poor families in the *Bolsa Família* Program (Brazil, 2012).
2. Ending hunger, achieving food security, improving nutrition, and promoting sustainable agriculture.	Promotion of healthy eating and food delivery to interest groups.	Promotion of healthy eating and reduction in child malnutrition and food insecurity (São Paulo, 2017). Implementation of vegetable gardens and full use of food (São Paulo, 2012).

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Chart 2 – Continuation

SDG No.	Santiago	São Paulo
3. Ensuring a healthy life and promoting well-being for all, at all ages.	Prevention of maternal and child mortality. Treatment of communicable and chronic non-communicable diseases. Promotion of physical and mental health and well-being. Prevention and treatment of smoking, alcohol consumption, and drug use. Universal access to the most vulnerable groups. Training, development, and retention of health professionals. Risk reduction and management.	Prevention of maternal and child mortality. Treatment of communicable and chronic non-communicable diseases. Promotion of physical and mental health and well-being. Prevention and treatment of smoking, alcohol consumption, and drug use. Universal access to the most vulnerable groups. Training, development, and retention of health professionals. Risk reduction and management. Prevention of deaths and injuries from road accidents.
4. Ensuring an inclusive, equitable and quality education and promoting lifelong learning opportunities for all.	Coping with vulnerabilities that may compromise the educational development and integral education of students in municipal schools.	Coping with vulnerabilities that may compromise the educational development and integral education of students in municipal schools (Brasil, 2017).
5. Achieving gender equality and empowering all women and girls.	Gender equity. Domestic violence prevention. Protection against gender violence. Comprehensive sexual and reproductive health care.	Fight against gender violence. Universal access of women to sexual and reproductive health.
6. Ensuring the availability and sustainable management of water and sanitation for all.	...	Incentive to the rational use of water and support to water cleaning projects and environmental surveillance (São Paulo, 2012).
7. Ensuring reliable, sustainable, modern, and affordable access to energy for all.	...	Incentive to energy efficiency in public administration and in the community (São Paulo, 2012).
8. Promoting sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all.	Health promotion and incentive to the performance of preventive health tests in workplaces. Management and development of health service workers.	Follow-up of guidelines for the detection and notification of work-related diseases. Management and development of health service workers.
9. Building resilient infrastructure, promoting inclusive and sustainable industrialization, and fostering innovation.	Increase and improvement of the existing health infrastructure. Innovation in the use of information and communication technologies. Accessibility and equity of care.	Increase and improvement of the existing health infrastructure. Innovation in the use of information and communication technologies. Universal and equal access. Rational use of resources.
10. Reducing inequality within and between countries.	Equitable access and embracement, regardless of ethnicity or nationality. Services focusing on interculturality.	Equitable access and embracement, regardless of ethnicity, skin color, nationality, or sexual orientation. Specific care policies to reduce inequalities.

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Chart 2 – Continuation

SDG No.	Santiago	São Paulo
11. Making cities and human settlements inclusive, safe, resilient, and sustainable.	Participatory diagnosis. Prevention and management of contingencies caused by disasters. Efficient use of resources.	Participatory management. Resource optimization. Environmental agenda. Revitalization of public spaces. Prevention and mitigation in risk areas (São Paulo, 2012).
12. Ensuring sustainable patterns of production and consumption.	Reduction in the use of paper. Training in environmental management.	Commitment to the SDGs. Waste reduction. Education for sustainability (São Paulo, 2012).
13. Taking urgent actions to combat climate change and its effects	Prevention and management of natural disasters.	Awareness of professionals for the relationship between climate change and health (São Paulo, 2012).
14. Conservation and sustainable use of oceans, seas, and marine resources for sustainable development.	...	Support for the depollution, cleaning, and maintenance of rivers and streams (São Paulo, 2012).
15. Protecting, restoring, and promoting the sustainable use of terrestrial ecosystems, sustainably managing forests, combating desertification, stopping and reversing land degradation, and stopping biodiversity loss.	Promotion of a healthy lifestyle in addiction to elements of environmental protection.	Incentive to the conservation and preservation of areas of ecological interest. Preservation of water sources. Expansion of green areas and vegetation cover. Protection of biodiversity and responsible animal ownership (São Paulo, 2012).
16. Promoting peaceful and inclusive societies for sustainable development, providing access to justice for all, and building effective, responsible, and inclusive institutions at all levels.	Violence prevention and treatment of assaulted people. Social participation, focusing on civil rights and social protection. Accountability and transparency.	Violence prevention and treatment of assaulted people. Participatory management. Promotion of citizenship and human rights. Accountability and transparency.
17. Strengthening the means of implementation and revitalizing the global partnership for sustainable development.	Networking and strengthening of intersectoral action. Participation of actors and co-management. Use of technologies to increase data availability and quality and for accountability.	Networking and strengthening of intersectoral action. Participation of actors and co-management. Use of technologies to increase data availability and quality and for accountability.

Discussion

We compared two important municipalities in Latin America. Both have different physical, epidemiological, and organizational conditions, but, even so, PHC participates cross-sectionally in almost all goals of the 2030 Agenda. However, the lack of explicit reference to the SDGs in the Santiago Health Plan, as well as the lack of knowledge of the relationship between some SDGs and PHC activities in São Paulo are concerning.

Jacobi and Giatti (2015) state that the search for compliance with the SDGs requires reflection and

actions based on the dialogue between constraints and local, regional, national, and global perspectives. In this sense, goal 17.14 of SDG 17 is clear in pointing out the need for coherence between sustainable development policies. Thus, the PHC agenda in the American continent is fully consistent with the SDGs, as it follows anti-poverty actions based on the principle of intersectoriality (PAHO, 2008). The Declaration of Astana is also clear regarding universal health coverage and the SDGs, in line with and supporting national policies, strategies, and plans (WHO, 2018).

Chotchoungchatchai et al. (2020) state that PHC does not contribute only to the fulfillment of SDG 3, but also to other health-related goals that require multisectoral action and citizen empowerment. In turn, Hone et al. (2018) assure that PHC contributes to the fulfillment of all SDGs because inequities are a cross-cutting theme in many of them—PHC is committed to equity and this commitment is strongly linked to actions on the broadest health determinants, since it targets the poorest and most vulnerable groups. Therefore, countries that invest primarily in PHC are more likely to achieve the SDGs than those with hospital-focused systems or limited investments in health.

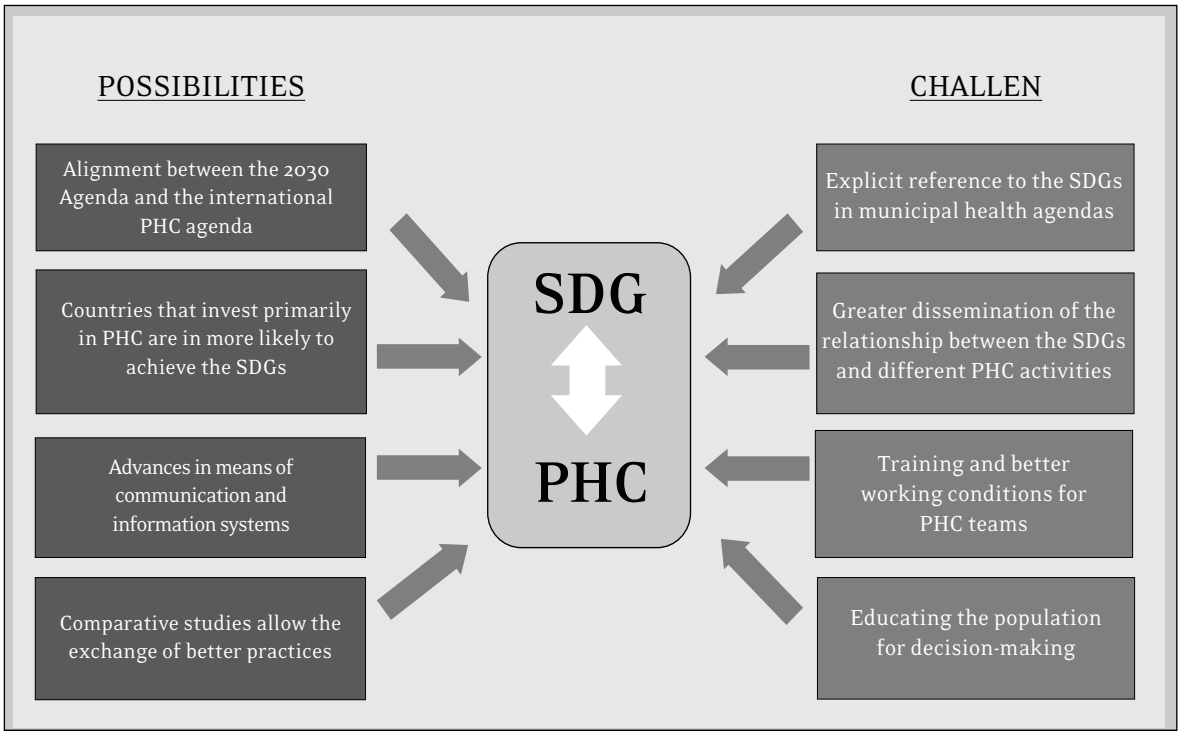
The Brazilian and Chilean actions are examples of the efforts of some countries to adopt comprehensive PHC, which includes community engagement and participation in family health practice. However, the two municipal agendas analyzed need to reinforce the significance of their actions. Although both seek to embrace the most vulnerable groups, no detail explicitly recognizes that an action contributes to poverty reduction, for example. Santiago developed actions to care for pregnant women and newborns, but did not establish that the fight against maternal and child mortality is among them. In São Paulo, the actions of the Green and Healthy Environments Program (PAVS) met 11 of the 17 SDGs (São Paulo, 2012), but in the city health plan, this program was only related to SDG 12 (responsible consumption and production).

Promoting actions without understanding the magnitude of its importance may be the reason why some national and local governments do not recognize the global value of strengthening PHC and avoid allocating greater political and financial resources to this sector (Chotchoungchatchai et al., 2020). This situation may also be responsible, at the local level, for the lack of communication with other sectors and even between different PHC professionals, which makes some team members not understand their own role in the organization and thus society also does not recognize their role in the system (Dos Santos, 2018).

PHC is not responsible for providing all actions to fulfill the SDGs, but provides a platform for all sectors to participate in actions in their territory (Hone; Macinko; Millett, 2018). Aligning local plans with national and global plans is necessary, considering means of communication and information systems, which open new ways for transparency and accountability as they advance (WHO, 2018). In this sense, the territorial dimension is indispensable, since policies meet each other and generate the necessary synergies in space and its various scales (Gadelha et al., 2011). The use of geoprocessing, for example, is a possibility to optimize the necessary interaction between different ways of understanding and acting on the territory, providing opportunities for the desired fronts of interaction, dialogue, and cooperation (Pereira; Barcellos, 2006; Salinas Rebolledo; Chiaravalloti Neto; Giatti, 2018). Similarly, Chotchoungchatchai et al. (2020) recommend a significant increase in the financial commitment to the health sector, particularly PHC, improving working conditions and the training to develop actions with the community and other sectors, as well as developing tools to increase health knowledge within the population and improving community involvement in decision-making.

Finally, the comparison between agendas can be useful for the mutual learning of experiences between these and other municipalities. Sharing experiences is also a way to achieve sustainable development, just as the exchange of the best practices is essential to renew PHC (PAHO, 2005). Thus, we propose a synthesis to promote convergences between the planning of PHC actions and the SDGs (Figure 2), presenting both possibilities that stimulate and facilitate this integration of actions and challenges that must be overcome.

Figure 2 – Possibilities and challenges for the joint planning between SDGs and PHC actions



Final considerations

PHC proves to be essential to achieve the SDGs, as it participates cross-sectionally in the goals of the 2030 Agenda. However, municipal health plans do not adequately specify this relationship, which could compromise the achievement of the SDGs due to the lack of incentives in this sector. Therefore, in order to ensure better political and financial support, a greater alignment between local health plans and national and global action plans is needed, as well as integrated and continued training for communities and health teams, using technologies to improve the territorial and intersectoral approach to the services as an essential condition for the applicability of sustainable development concepts.

The introduction of the 2030 Agenda, in accordance with the Declaration of Astana and the Essential Public Health Functions in the Americas, the training in the use of information and communication technologies and in spatial analysis tools in health, for the elaboration of intersectoral projects directly linked to the achievement of the SDGs, are critical training areas for community health teams.

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Author's contribution

Salinas and Giatti designed the study, wrote the first version of the manuscript, and performed its final revision. Salinas also participated in data collection, curation, and analysis.

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