Social participation and Primary Health Care in Brazil: a scoping review

Participação social e Atenção Primária em Saúde no Brasil: uma revisão de escopo

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Abstract

This article aimed to carry out a scoping review of the literature to understand the formal experiences of social participation that have been developed in the context of the Brazilian Primary Health Care (PHC), since the creation of the Brazilian National Health System (SUS) until November 2020. The databases LILACS, PubMed, PsycINFO, and Sociological Abstracts were searched, and 20 articles were included that described the social participation in the context of PHC. The results found were discussed regarding the profile of the participants and the competence to participate, the process of participation and the building of participatory actions, and the centrality of permanent education as a way to strengthen social participation in health. The research revealed distinct experiences of social participation developed in the territories where the PHC operates, highlighting the difficulties faced in the process of implementing the Local Health Councils (LHC). Thus, it is understood that strengthening the PHC, especially the Family Health Strategy (FHS) model, involves, in a dialectical way, the construction and the qualification of participatory spaces, which would result in a central strategy to defend the SUS at this time of resurgence of democratic relations in Brazil.

Keywords: Social participation; Health councils; Primary Health Care; Democracy.

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Resumo

O presente artigo objetiva realizar uma revisão de escopo da literatura, com o intuito de compreender as experiências formais de participação social que tem sido desenvolvidas no contexto da Atenção Primária em Saúde (APS) no Brasil, desde a criação do Sistema Único de Saúde (SUS) até novembro de 2020. Foram realizadas pesquisas nas bases Lilacs, PubMed, PsycINFO e *Sociological Abstracts*, sendo achados 20 artigos abordando a participação social e a APS. Os resultados encontrados foram discutidos no que se refere ao perfil dos participantes e à competência para participar, ao processo de participar e à construção de ações participativas, além da centralidade da educação permanente como forma de fortalecer a participação social em saúde. A pesquisa revelou distintas experiências de participação social desenvolvidas nos territórios onde atua a APS, destacando-se as dificuldades enfrentadas no processo de implementação dos Conselhos Locais de Saúde (CLS). Sendo assim, discute-se que o fortalecimento da APS, principalmente do modelo Estratégia Saúde da Família (ESF), envolve, de modo dialético, a construção e qualificação dos espaços participativos, o que resultaria em uma estratégia central de defesa do SUS em um momento de recrudescimento das relações democráticas no país.

Palavras-chave: Participação social; Conselhos de saúde; Atenção Primária em Saúde; Democracia.

Introduction

From the 1988 Constitution, a new reference to social rights was reconfigured in Brazil. The right to health becomes a right of all citizens and a duty of the State, which must be integral and guarantee the promotion, protection, and recovery of health, and include the participation of society in deliberative processes (Brasil, 1988).

Law No. 8,142, December 20, 1990, regulates society's participation in the Unified Health System (SUS) management through Health Councils and Conferences (Brasil, 1990). The conquest of these spaces of involvement was a decisive factor in organizing a democratic institutionality, without which the right to health could not become effective as a right of citizenship. According to Resolution No. 453, the participation of organized society, guaranteed by law, makes the Health Councils (HC) privileged instances in proposing, discussing, monitoring, deliberating, evaluating, and supervising the implementation of health policy, including its economic and financial aspects (Brasil, 2012).

The success of the health decentralization process promoted the emergence of Regional Councils, District Councils, and Local Health Councils (LHC), thus developing a participatory management process ever closer to the people and their needs. Today, such forums bring together thousands of healthcare users, professionals, and managers to the definition of health policies in their localities.

Gohn (2003) emphasizes the importance of local power and social force, organized as a form of participation for community empowerment. Therefore, not only is the possibility of democratizing decisions provided, but also the concrete opportunity to ensure that the real needs of the population are met. When the contact between representative, community, and public power occurs more directly, the representation proves to be more effective (Guizardi; Pinheiro, 2006). Thus, the expansion and strengthening of participatory spaces inserted in the daily functioning of health services act as an essential strategy to understand the

problems and conditions of local health, allowing the population to determine and voice them (Miwa; Serapioni; Ventura, 2017; Paim, 2012; Bispo Júnior; Martins, 2014).

A critical discussion focuses on the potential that Primary Health Care (PHC) has in transforming society-State relations, as it acts as a unique process that considers and includes locoregional specificities and the dynamics of the territory. Being the main gateway to the SUS, the communication center of the Health Care Networks (HCN), and establishing care coordination and ordering the actions and services made available to healthcare users, it becomes a space capable of stimulating the organization of local systems and bringing services closer to the reality of the population, strengthening social participation in health (Brasil, 2017).

The choice of PHC as the reflective focus of this study is given not only because of its capillarity or because it means the reorienting focus of the health care model in Brazil but mainly because of the potential for innovation that this policy presents, being the scenario of numerous successful participatory management, education, and social mobilization experiences. Therefore, it can be considered a social laboratory with a multiplier effect of learning based on the actions and experiences it enables at the local level (Paim, 2012; Carneiro et al., 2014).

Therefore, to understand social participation in the context of Brazilian PHC and how the ideals of voicing social demands and the democratization of health have been fulfilled since the creation of the SUS, the present study aimed, through a scoping review, to map the empirical academic production on this theme, bringing to the discussion the different formally instituted experiences of social participation – for example, in Local Councils – developed in the territories where PHC operates.

Methodology

A literature scoping review was performed. Therefore, it is a type of investigation that starts from a broader question and allows mapping of the key concepts that support an area of research and the primary sources and types of evidence available in the literature (Arksey; O'Malley, 2005). While it presents itself as a more comprehensive coverage tool of the available studies, it can be constructed in different degrees of depth, depending on the purpose of the review and the amount of information extracted from the analyses. Due to their goals and the diverse nature of the included studies, scoping reviews generally do not assess the risk of bias or summarize findings through meta-analysis or meta-synthesis (Munn et al., 2018). Therefore, the present study sought to map the types of research, how they are carried out, their characteristics and key factors related to social participation in PHC, and knowledge gaps on the subject.

Therefore, this research occurred based on the recommendations of the international guide Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). For the formulation and guidance of the guiding question, the Population, Concept, and Context (PCC) strategy (JBI, 2015) was adopted based on the following research question: what are the experiences of social participation in the context of Brazilian PHC from SUS (1988) inception until November 2020?

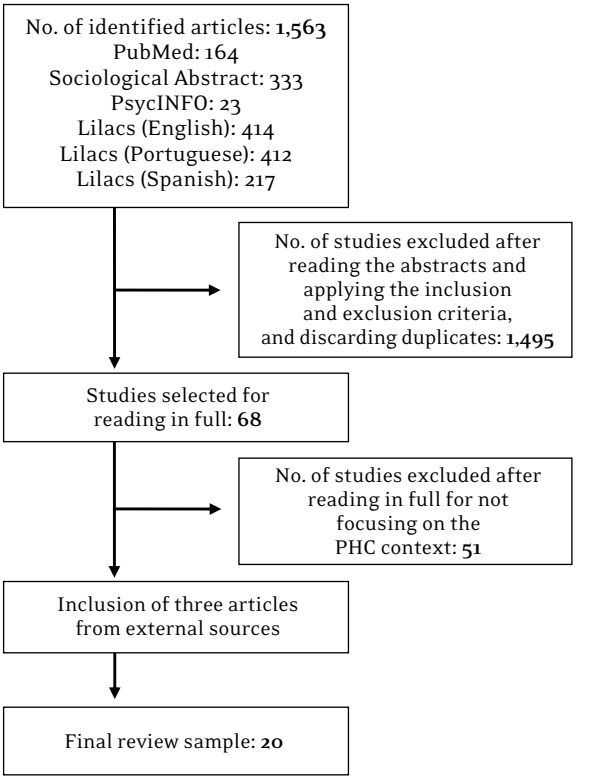
The following search strategy was used to identify the available academic production: ("social participation" OR "community participation" OR "social control" OR "social mobilization" OR "public deliberation" OR "public participation" OR "participatory democracy" OR "deliberative democracy" OR democra* OR "citizen participation" OR "citizenship in health" OR "consumer participation" OR "participatory management" OR "civil society") AND ("primary health care" OR "family health strategy" OR "family health program" OR "basic health unit" OR "family health" OR "municipal health council" OR "local health council" OR "health councils" OR "health centers") AND (Brazil*).

The databases consulted were Lilacs, PubMed, PsycINFO (APA), and Sociological Abstracts (ProQuest). In the international databases, descriptors in English were used, and in the Latin American and Caribbean database, terms in English, Spanish and Portuguese were used. The choice to include international databases was due to their scope and sensitivity in the retrieval of Brazilian studies published in journals worldwide. EndNote X9 manager was used for data organization.

Three researchers selected the studies independently in two stages: the first to choose based on the abstracts and then, the selection among the articles read in full. In case of disagreements, a fourth researcher was consulted. Studies that met the following criteria were included: (1) empirical research reports - of a quantitative and qualitative nature - focusing on the formal mechanisms of social participation in health that involved the context of Brazilian PHC and that had their results obtained through primary data; (2) present clearly defined objectives, methods, and results in the abstract; (3) the research was carried out with social actors - managers, professionals, and users - involved in the PHC context; and (4) be within the time frame of 1988 - the creation of the SUS - until November 10, 2020, i.e., the last date of the search. Finally, theoretical works, educational materials, theses, and dissertations were excluded.

The search strategy resulted in a total of 1,563 citations. After discarding the duplicates, reading their abstracts in detail, and applying the indicated criteria, 68 studies were read in full. Subsequently, 51 more that did not meet the abovementioned requirements were excluded, resulting in 17 articles. After this selection, when consulting the bibliographic references of the studies, three more were included as external sources, finally making a total of 20. The flowchart in Figure 1 presents the steps of the article selection process.

Figure 1 – Flowchart of the selection process of studies on formal mechanisms of social participation in health involving the context of Brazilian Primary Health Care, 2021



The following data from the included studies were extracted and tabulated: authors, year, study location, period of data collection, study design, instruments, participants, primary results, and *Qualis* of the journal of publication - for the area of evaluation in Collective Health and, when not available, to the Interdisciplinary area. The results were analyzed descriptively and qualitatively, using Thematic Analysis (Minayo, 2010) to investigate forms of social participation in health in the PHC context.

Results and discussion

Table 1 describes locations, year of implementation, participants, methodology, primary results, and the *Qualis* of the journals in which the included studies were published.

Table 1 – Characteristics of studies on formal mechanisms of social participation in health involving Brazilian primary care (n=20)

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Barroso and Silva (2015)	Datas, Diamantina, Senador Modestino Gonçalves, and Presidente Kubitscheck, Vale do Jequitinhonha, MG. Oct.-Dec./2007.	Cross-sectional; descriptive quantitative/ Questionnaire.	Forty municipal councilors.	The identification profile of the councilors: female gender (72.5%), with higher education (52.5%), and with employment ties linked to the public health services of the respective municipalities (35.0%). The proportions of the segments of society represented are health workers (30.0%), users (27.5%), health service providers (12.5%), and government (7.5%). The main form of the election was via indication by the Municipal Health Secretariats (MHS)) (37.5%), followed by referral by some association/entity in which they participate (37.5%). Regarding their performance, most consider themselves very participative in working as councilors (87.5%). Concerning the relationship between municipal health councilors and PHC, while they report knowing the services and their problems, there is low participation in meetings at the Basic Health Units (BHU), where they are users. In conclusion, there is a weakness in exercising social control in the PHC and the need for closer contact between councilors and these services.	B4
Bispo Júnior and Martins (2012)	Vitória da Conquista, BA. Mar.-Jun./2009.	Cross-sectional; descriptive quantitative, and qualitative; multiple case study/ Document analysis (the period between Mar./2007-Feb./2009, except January) and interviews.	Thirty-six local councilors.	Regarding the frequency of LHC meetings, the majority held those that were planned (53.6%); on the agreed themes, they refer to social mobilization and community participation (37.7%), the internal organization of the LHC (20.8%), difficulty in assisting in the Family Health Program (FHP) and specialized referrals (20 .4%), low community participation, and issues related to the organization of LHC itself (18%). Regarding the performance of the LHC, while there is a consensus on its importance for improving the community's living conditions, the interviewees perceived it as still incipient due to issues of representativeness and fragility of community organizations. They highlight that the participation of some healthcare users is motivated by individual interests related to facilitating access to health services, demonstrating misunderstandings about the purposes of LHC and the weaknesses of SUS and FHP in guaranteeing dignified assistance to the population.	B1
Busana, Heidemann, and Wendhausen (2015)	Municipality of SC. Jun.-Sep./2013.	Cross-sectional; qualitative/ Structured questionnaire; field diary; focus group (5 culture circles).	Eleven councilors from a LHC (nine healthcare users and two health professionals).	The characterization of the participants was: age between 37 and 64 years old, seven men and four women; the majority with higher education or complete elementary education; self-employed or retired. The research had five culture circles addressing the potentialities and limits of participation in the LHC. After the meetings, 39 generating themes were coded and decoded. Among its potentialities is the possibility of exercising citizenship, constituting an educational space, and the intention to make decisions representing the community. Concerning the limitations, lack of knowledge about the council's responsibilities, lack of community participation, and discredit.	B1

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Domitrovic, Araújo, and Quintanilha (2013)	Vitória, ES. No collection period.	Cross-sectional; qualitative/ field diary and interviews.	Eight local councilors (four from each LHC) and two psychologists (one from each BHU).	LHC with monthly meetings, between nine and 10 participants, predominantly female. Thematic axes: reports from partner institutions and instances (Cras, Cajun, and the Management Collegiate – BHU internal instance, meetings between professionals and during working hours); campaigns and programs carried out at the BHU (councilors representing the workers pointed out the low adherence to the actions due to little disclosure, and asked the representatives of the healthcare users to pass on information to the community); structural problems in the neighborhoods served by the BHU (flooding of a square, accumulation of garbage in a vacant lot, faulty wiring, clogged maintenance holes, and lack of recreational spaces for children – expanded notion of health –; some interviewees showed ignorance of the function of the LHC with questions of personal interest); internal problems at the BHU (physical conditions, more professionals, occasional complaints about the functioning of the BHU, emptying of the LHC, participation restricted to the performance of a few representatives). The expressions "we" and "they" frequently appear in the speeches.	B4
Franchi et al. (2012)	Botucatu, SP. Sep.-Oct./2008.	Cross-sectional; qualitative/Interviews.	Nine councilors of healthcare users from four Health Unit Councils (CONUS), three Family Health Strategy (FHS), and one Health Center – São Paulo State University (UNESP).	It results in three categories: the first, "Knowing the user/councilor," presents the profile of the councilors – three women (33.3%) and six men (66.7%) –; aged from 35 to 70 years old, seven (77.7%) of them over 56 years old; the majority (77.7%) retired or housemaker; all attend associations outside the Council, churches, and pastoral care, followed by groups for the elderly, neighborhood associations and councils for the elderly; and most have served more than one term. In the second category, "The Council of Health Units," most participants learned about the Council from BHU employees and CONUS members. Although they considered the first meeting not very participatory, they positively evaluated the influence of the Council in their lives – emphasis on interpersonal relationships and critical ability. Finally, in the third category, "Participation in the Council," the majority considers CONUS active, cooperative, and without conflicts; while they believe in social participation, one says that it does not work in practice, that there is little interest from the community; however, the perception of an improvement in health care after the CONUS action is unanimous and that the Council influences health management and political representatives.	B4

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Jerome (2018)	Fortaleza, CE. 2015-2017 (second half of each year).	Cross-sectional; qualitative/participant observation and interviews.	Seven BHU; six presidents of LHC.	All seven BHU had at least one dentist and one pharmacy on-site, six of which were LHC. Meetings with 12 or fewer participants (half under five), age range, even number of men and women, and high school education. All six LHC presidents resided and grew up in the neighborhoods, and five were former and/or current members of community organizations with active participation in the community's historic struggle. Main themes presented: missing medicines and problems with staff; deficient infrastructure to carry out the work of the LHC (they asked for adequate space and material resources for meetings, such as its room, air conditioning, pens, and papers); and lack of proper representation at meetings. Difficulties pointed out: the presence of BHU coordinators at meetings inhibits the community from reporting problems (they may need "favors"); socioeconomic and educational differences of the healthcare managers compared to the other members of the LHC. Improvements made: advocating for residents; taking care of the physical structure; hiring a security guard at BHU; constructing a wider concrete perimeter around the school; and creating a revenue collection program at bus terminals (local ideas that impacted health initiatives across the city).	B1
Junglos et al. (2019)	Capital in the southern region. Jan.-Mar./2017.	Cross-sectional; qualitative/Interviews.	Fifteen local councilors.	Regarding the councilors' profile: most are over 50 years old (93%), male (60%), retired (80%), and participated in the councilor training course (66%). Concerning performance time, most have been working for less than two years (40%). Four categories emerged: Motivations for acting in the LHC (improving the community; having a history of social participation; personal indignation; right/duty to participate; being able to help by having a network of favorable relationships); Importance and performance of the LHC for the SUS (information on the health situation of the community; purposeful and supervisory space for health services); Challenges of participation in the LHC (expanding participation, individualism, the influence of party politics, lack of knowledge of the population); Prospects for action and strengthening of the LHC (more willing to help the community, more people participating and efficient management in the SUS).	B4
Lisboa et al. (2016)	Anchieta, ES. Jun.-Sep./2013.	Cross-sectional; qualitative/Interviews.	Thirteen local councilors.	From the LHC implementation process, categories emerged: to be or not to be a health councilor? That is the question! (opportunity to vocalize the interests of the community, but still the unpreparedness to exercise the function); non-belonging and non-participation (disbelief of the population concerning the local politics, the community has little knowledge of the LHC existing in the municipality, they only participate in elections; non-belonging can be explained by the turnover of residents due to the installation of multinationals in the territory); and LHC: links, means, and mediations (lack of support and feeling of abandonment by management as discouraging factors in the face of the development of LHC, in addition to disappointments with the Municipal Health Council – MHS).	B1

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Lopes and Almeida (2001)	Londrina, PR. No collection period.	Descriptive quantitative and qualitative/Interviews.	One hundred eighty-three local councilors (who attended at least one meeting in the first half of 1999).	Distribution of the 38 LHC in the urban area, according to regions: eight are in the east zone, eight in the north zone, seven in the west zone, nine in the south zone, and six in downtown. According to the classification: 25 (65.8%) were active, five (13.2%) were in the formation phase, four (10.5%) were non-existent, three (7.9%) were not functioning, and one (2.6%) was in the reactivation phase. Regarding the profile of the Councilors: 56.3% were women, although men primarily held the positions of presidents (ratio 15 to 10); 38.2% were employed, 30.6% unemployed, and 31.2% self-employed; 47% had an income higher than six minimum wages; 49.8% had never participated in training courses for Councilors. Qualitative analysis concerning the function of the LHC: joint work, need for population organization, supervisory role, space for complaints, participation in planning, and change in the care model. Despite the variety, the speeches were restricted, for the most part, to charging, asking for things, or claiming rights. Regarding the concept of health, most were established by Law No. 8,080/1990 (53.5%), followed by the simple concept of absence of physical illness (25%). Concerning the actions carried out by the Councils: the most brought resolution of problems in the BHU (more doctors, medicines, and services), but there were also actions in the environment and favor of the community. Regarding internal difficulties: lack of physical, financial, and organizational structure, non-compliance with meeting dates and times, and lack of prior agendas and meeting records. Concerning the external difficulties: lack of population participation in meetings and activities. Regarding the relationships between LHC, MHC, RHC, and Higher Education Institutions (HEI): RHC contributes to LHC but could be more participatory; the MHC should be more participative and resolving; HEI helps improve and praises interns. However, a criticism concerns the lack of feedback on survey results and the discontinuity of services after the survey.	B2
Martins and Santos (2012)	Juiz de Fora, MG. No collection period.	Cross-sectional; qualitative/Interviews.	Fifteen nurses active in LHC (seven councilors, seven BHU management representatives, and one listener.)	Profile: most graduated more than ten years ago (73%), have postgraduate training (87%), most in the collective health (CH) area in FHP (47%), worked in BHU for an average of seven years, worked in LHC for four years. First category: Performance of nurses in the LHC (they believe they contribute to improving health conditions and services provided by the BHU, for some, it is just the role of disseminating, informing, guiding, and raising awareness of the services offered by the BHU). Second category: the participation of the community and the nurse in the LHC (social control can be expanded by interaction with the community, financial resources, social control, and the assistance model for the democratic and sanitary model, councilor as a partner of the BHU, unpreparedness of councilors to act in LHC, clientelism attitudes, or partisan interests). Third category: community, nurse, and the LHC, given the policies defined by the SUS and the health actions carried out by the BHU (LHC performance is good, but only proposals promoted by the BHU are supported).	B1

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Mittelbach and Perna (2014)	Curitiba, PR. Jan.-Jul./2012.	Cross-sectional, quantitative, and qualitative/Interviews.	Eighteen nurses from the BHU.	Nurses' concept of what Social Control is: space for agreement between managers and users (50%), followed by a way for society to improve the SUS (20%). Nurses' performance in the HC: guide users on how they should participate in HC meetings, explaining the importance and functioning of this space (83%). Limitations for the participation of nurses in the HC: lack of interest in political action (23%), lack of personnel in distant or small BHU (20%), time (night) for meetings (18%), double shifts (18%), loss of interest as it is a space used by users to obtain facilities or personal prestige (12%), the self-indulgence of professionals (9%). Advances in the participation of nurses in the HC: a more significant number of professional nurses in the network (52%), greater politicization of nurses (26%), in the BHU where professionals work, there is no restriction for participation in the LHC (22%). Influence of nurses in LHC on Nursing work: request for security personnel (Municipal Guard) (50%), physical renovations in the BHU (27%), more nursing professionals for the BHU (11%), the definition of points for vaccination outside the BHU during campaign periods (6%), and construction of an access ramp for people with special needs at the BHU (6%).	B4
Miwa, Serapioni, and Ventura (2017)	Ribeirão Preto, SP. Oct./2015-Jul./2016.	Cross-sectional; qualitative; case study/Interviews, direct observation, and minutes analysis (2015-2016).	Twenty-two people (16 healthcare users and six local councilors).	Profile of interviewees: mostly women, elderly, retired, with incomplete high school, and who usually attended health promotion groups organized at the BHU. The following categories emerged: LHC invisibility (most are unaware of the LHC, lack of information, LHC activities are not disclosed in promotion groups, there are almost no new participants, healthcare user representatives have a history of participation in conferences and social movements allowing to expand the agenda of the meeting); Ignorance, disbelief, and dependence on competent bodies (healthcare users are unaware of representatives, delay in resolving demands, passive attitude, and dependence on the institution); Alternatives to leave anonymity (Community Health Agent – CHA and their mediating role, expansion of the dissemination of LHC activities and identification of healthcare user representatives, dissemination of the expanded concept of health, strengthening of health promotion groups, training of councilors, and more significant interaction between LHC and MHC).	B1
Oliveira and Dallari (2015)	Belo Horizonte, MG. Oct./2013-Jun./2014.	Cross-sectional, qualitative; single case study/Document analysis and participant observation (field diary).	Three Local Health Commissions with opposite Social Vulnerability Index (SVI).	Regarding the dynamics of participation and deliberation, two LHC have organization and operating rules established in the statute and are competent to deliberate on problems (the internal regulations also provide decision-making power in the area covered by the BHU). The topics on the agenda were proposed at the last annual meeting and were brainstormed by BHU managers. Discussion themes: garbage issue, violence, elections, and network of connections. When analyzing the local networks and their relationships through the PHC, the horizontal flow of information arising from the discussions that allowed monitoring and monitoring public policies was highlighted.	B1

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Pestana, Vargas, and Cunha (2007)	Teresópolis, RJ. No collection period.	Cross-sectional; qualitative; case study/Minutes analysis; interviews.	Councilors of The Management Council (MC) of The Family Health Unit (FHU) – no "n" informed.	Regarding the contradictions of the MC: dissociation between the population's needs and the proposal of the BHU, based on the government's health programs; appropriation of the discourse of healthcare managers and health professionals by popular leaders (ideological domination); healthcare users want to be assisted by the BHU doctor (logic of the medical-assistance model); fear of councilors representing healthcare users of confronting health professionals and, in the future, needing assistance; councilors representing healthcare users and health professionals cultivate a dependency concerning the councilors representing the healthcare manager (the meeting is suspended when the representatives of managers do not attend); councilors exercise attributions that are devoid of political sense (MC was unable to interfere in health policy and in the allocation of public funds); members of the Health Secretariat responsible for calling meetings (health professionals and healthcare users represent 75% of the members of the MC, revealing a sufficient quorum to meet and deliberate); MC does not have decision-making power in resolving community demands.	B1
Ponte et al. (2019)	Sobral, CE. Sep.-Nov./2016.	Cross-sectional; qualitative/Interviews; minutes analysis.	Eight Councilors nurses (having been a Councilor between 2008-2016).	"Awakening to participation and social control" shows that there are few direct relationships with the inclusion of social control in academic training; the nurse-councilors participating in the study unanimously say that the student movements were the first contact with social control as a way to qualify the services provided. Subsequently, joining the PHC universe in the FHS space strengthened this interest. In the entitled "Contributions of participation as a Councilor for professional performance," they report that being or having been a Councilor at the MHC brought professional and personal development, encouraging a more critical and reflective look at community issues, in addition to humanizing relationships, strengthening bonds and active listening.	B1
Ribeiro and Nascimento (2011)	Feira de Santana, BA. No collection period.	Cross-sectional; qualitative/Interviews, systematic observation, and document analysis.	Seventeen FHU subjects in implementing the LHC (key informant and health committee members).	Understanding social control in the LHC formation process: the representation of the social subject (instrumentalization for the exercise of social control, inexpressive bureaucratic representation); education as fundamental for the implementation of the LHC (healthcare user representatives rarely attended the meetings and, if they were present, they expressed little). The process of social mobilization for implementing the LHC is moving slowly, with few critical, participatory subjects and promoters of the ideal of participation.	B3

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Tilio (2014)	Uberaba, MG. Jan./2012-Oct./2013.	Cross-sectional; qualitative/ Participant observation and field diary.	Health and education team, management, and persons deprived of liberty (PDL) of Professor Aluízio Ignácio de Oliveira Penitentiary (PPAIO).	Participation of PDL in health management in the penitentiary institutional context was based on two actions: (1) training of PDL to be multiplier health agents, and (2) creation of a LHC (considering that PPAIO had a BHU and followed the structuring legislation of the SUS). Two moments are highlighted: the first covers seven meetings and main demands (establishment of the council, the election of members and the board of directors, approval of the internal regulations, questions about the reduced number of medical, dental, and psychological consultations, acquisition of medicines and health materials, mainly dental, clarifications on the distribution of medication and assistance/social security services, such as social benefits for the PDL and their families, the need for fumigation of the pavilions, daily collection and proper disposal of garbage, and the forwarding of demands to the MHC, to make visible the sanitary conditions of the penitentiary. The second moment covers six meetings: with the intensification of the needs of the PDL in the LHC meetings, the penitentiary management responded with the demobilization of the LHC.	B2**
Vale et al. (2017)	Feira de Santana, BA. Apr.-May/2013.	Cross-sectional; qualitative/ Systematic observation and interviews.	Fourteen local councilors.	Regarding the councilors' profile: mostly men; continuous CHA occupation by retirees; age range from 30 to 40 years; black race; married; complete secondary level; Catholics and active in church social actions, political parties, community associations, or residents. Potentialities of the LHC – category "where there are several heads, there are several thoughts" (autonomy in social manifestations, feeling of representing a community and leading manifestation of local social interests, knowledge of the themes of the health sector for the practices of being a councilor and power of argumentation); Limits of the LHC – category "authoritarianism, political co-option, and little support" (little participation of the community and the councilors themselves, party influence, little recognition of the objective of the LHC, dissatisfaction related to the precarious physical structure destined to the meetings of the LHC and authoritarian and bureaucratic character of municipal management, councilor remuneration, articulation between LHC and MHC, decision-making of municipal management is little publicized, and instituted in a descending way.	B4

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Table 1 – Continuation

Author/ Year	Study location/ collection period	Study design/ collection instrument	Participants	Main results	*Qualis**
Vale and Lima (2015)	Feira de Santana, BA. No collection period.	Cross-sectional; qualitative/Interviews, systematic observation, and document analysis.	Sixteen local councilors (two from each LHC, one representing users and one representing health workers).	The main discussions of the LHC addressed PHC, transportation, and public safety (showing an expanded notion of health). The operation took place in an ample space belonging to the FHU in the neighborhood and complied with the internal regulations, monthly meetings, and maximum time stipulated; the coordinator was a mediator, the secretary was responsible for writing the minutes of the sessions, there was no verification of the quorum (they deliberated anyway). Regarding the experience of being a councilor: the feeling of personal accomplishment, gratification, donation, and help to others, LHC like a potentially transforming body of reality by ensuring the participation of the population in municipal management, LHC with a homologating character of public interests, integration with other segments social projects for intersectoral actions, and training of councilors.	B3
Varela et al. (2020)	Milagres, CE. Feb.-Jul./2016.	Cross-sectional; qualitative/systematic observation, document survey (between Oct./2013-Jun./2016) interview and focus group (field diary).	Twenty-two local councilors from a rural community.	The LHC is represented by healthcare users (primarily women; aged between 23 and 65 years, with high school education and housework) and workers of the FHS team (one dental surgeon and five CHA; three men and three women, aged between 32 and 65 years; minimum working time of six years and maximum of 25; two with higher education and two with secondary education). The following categories emerged: Contextualities in the implementation of LHC (municipal health conferences, National Program for Access and Quality Improvement in Primary Care (PMAQ-AB) and motivation of the FHS team); Formation of the LHC in the face of the daily situations of the community: health needs, participation, and renewal (organization of the LHC for the mobilization of healthcare users and health workers, highlighting the importance of the CHA); Difficulties faced in organizing the LHC (at first there was low adherence by the population, but the councilors were able to mobilize the community, causing the group to mature and the identity of the LHC to be built).	B3

*: *Qualis* in the Collective Health area; **: *Qualis* in the Interdisciplinary area.

Most studies were qualitative, predominantly using interviews and/or questionnaires as data collection instruments (Table 2). Most of them had LHC as their field of research, with the Southeast region presenting most studies. Concerning the period when the studies were carried out, most occurred between 2007 and 2017. However, many articles did not detail this information. Regarding the year of publication, it varied between 2001 and 2020, with most studies published between 2007 and 2017. It is also important to note that although the SUS has guaranteed social participation from 1988 onwards, in the Organic Law of the Health (OLH), the studies found are only from 2001.

Concerning the *Qualis* of journals, most were published in journals with a B1 grade. However, one of the articles (Tilio, 2014) was published in a journal that did not have an evaluation of the Collective Health area. Therefore, the Interdisciplinary area *Qualis* was considered.

Table 2 – General description of articles selected for review (N=20)

	N	%
Study Design		
Qualitative	16	80
Quantitative	1	5
Mixed	3	15
Data collection instrument*		
Interviews/Questionnaires	18	48,6
Focus Group	2	5,3
Observation/Field Diary	9	24,3
Document Analysis	8	21,6
Participatory spaces studied		
Local Health Council (LHC)	12	60
Municipal Health Council	2	10
Health Management Council	1	5
LHC+Basic Health Unit	5	25
Regions		
Northeast	7	35
Southeast	11	55
South	2	10
Data Collection Period		
2007-2011	3	15
2012-2014	6	30
2015-2017	5	25
N/A**	6	30
Publication Year		
2001-2006	1	5
2007-2014	9	45
2015-2017	6	30
2018-2020	4	20
Collective Health *Qualis*		
B4	6	30
B3	3	15
B2***	2	10
B1	9	45

*: more than one instrument may have been reported in each study; **: not informed; ***: in one of the articles, the *Qualis* grade considered was from the Interdisciplinary area.

The thematic analysis of the studies allowed us to observe consensus and disagreement between the findings found. However, most focused on the limits and possibilities of social participation in health based on implementing formal mechanisms involving the PHC context. Therefore, based on the exhaustive reading of the studies, three thematic categories were identified and presented below, aiming to discuss the main arguments and analyses used in the different identified studies.

The profile of the participants and the competence to participate

This category exposes who are the subjects who participate in the HC, if there is a specific profile

of the representatives, and who are those who are interested in social engagement and the demands of the community.

In the studies that presented the descriptive profile of these councilors, five spaces surveyed had mostly women (Barroso; Silva, 2015; Varela et al., 2020; Domitrovic; Araújo; Quintanilha, 2013; Lopes; Almeida, 2001; Miwa; Serapioni; Ventura, 2017), four had more men (Busana; Heidemann; Wendhausen, 2015; Franchi et al., 2012; Junglos et al., 2019; Vale et al., 2017) and only one had a similar number of men and women. Lopes and Almeida (2001) show that, although most of the local councilors they surveyed were women, the positions of presidents were held mainly by men, which indicates that gender inequality also tends to perpetuate itself in these spaces.

Among the studies that brought the age range of those surveyed (Busana; Heidemann; Wendhausen, 2015; Varela et al., 2020; Franchi et al., 2012; Jerome, 2018; Junglos et al., 2019; Vale et al., 2017), results between 23 and 75 years old were found, with two of these studies specifying that most participants were over 50 years old (Franchi et al., 2012; Junglos et al., 2019).

Regarding education, four studies showed that councilors had completed or incomplete secondary education (Varela et al., 2020; Jerome, 2018; Miwa; Serapioni; Ventura, 2017; Vale et al., 2017), while another two revealed participants with complete higher education (Barroso; Silva, 2015; Busana; Heidemann; Wendhausen, 2015). Concerning occupation, the studies indicated a predominance of retirees (Busana; Heidemann; Wendhausen, 2015; Franchi et al., 2012), "housemakers" (Varela et al., 2020; Franchi et al., 2012), self-employed (Busana; Heidemann; Wendhausen, 2015; Lopes; Almeida, 2001), or civil servants (Barroso; Silva, 2015; Vale et al., 2017). Only one study described unemployed participants (Lopes; Almeida, 2001).

There was a tendency for HC participants to already have a participatory history in other spaces, such as in councils from other areas, entities, associations, or social movements (Barroso; Silva, 2015; Oliveira; Dallari, 2015; Franchi et al., 2012; Jerome, 2018; Junglos et al., 2019; Miwa; Serapioni; Ventura, 2017; Vale et al., 2017). Some studies specified councilors linked to churches and pastoral care (Franchi et al., 2012; Vale et al., 2017; Oliveira; Dallari, 2015) or health promotion groups organized within the Basic Health Units (BHU) (Miwa; Serapioni; Ventura, 2017). For example, Oliveira and Dallari (2015) highlighted the strong relationship with entities linked to the Catholic Church in one of the Local Health Commissions studied. In another, they also had links with partner entities that work with the community, generally philanthropic entities. However, a lack of articulation between these entities and the commissions was observed.

The studies referred to as central to the idea that it was a space to improve community life, vocalize collective interests, and exercise citizenship to understand the reasons that led the subjects to participate in the HC (Busana; Heidemann; Wendhausen, 2015; Junglos et al., 2019; Lisboa et al., 2016; Vale et al., 2017; Vale; Lima, 2015). Lisboa et al. (2016) discussed the position of councilors as political subjects who are aware of their rights and determined to fight for them but are often unprepared to exercise this role.

Regarding the skills needed to participate effectively, most of the studies described healthcare users' misunderstandings about the purposes of the HC and the discrediting of these spaces, as it was common to find members who participated only to obtain their benefits or, even motivated by partisan interests (Bispo Júnior; Martins, 2012; Busana; Heidemann; Wendhausen, 2015; Domitrovic; Araújo; Quintanilha, 2013; Jerome, 2018; Junglos et al., 2019; Lisboa et al., 2016; Martins; Santos, 2012; Mittelbach; Perna, 2014; Miwa; Serapioni; Ventura, 2017; Vale et al., 2017). In addition, community participation was often restricted to the performance of a few representatives, always the same, which ended up favoring some and showing little receptiveness to new ones (Domitrovic; Araújo; Quintanilha, 2013; Miwa; Serapioni; Ventura, 2017).

This community's search for favors and advantages for itself or close groups makes us reflect on the difficulty of recognizing the CS as spaces for collective struggles (Lisboa et al., 2016; Mittelbach; Perna, 2014), which therefore facilitates the co-option of user representatives and the influence of the local government. This compromises the HC's supervisory and deliberative role, contributing to the continuity of clientelism practices (Pestana; Vargas; Cunha, 2007;

Barroso; Silva, 2015). In this sense, Bispo Júnior and Martins (2012) point out that a mix of individualism and immediacy prevails on the part of the community, and some healthcare users tend to use participation in HC as a way to make assistance demands feasible. For the authors, misunderstandings about the purposes of the HC also demonstrate the difficulties of the SUS and the PHC in guaranteeing dignified assistance, which leads users to seek alternative paths.

Other reviewed studies showed subjects who did not express their own opinion in the HC for fear of generating misunderstandings with health workers and/or managers and, therefore, ended up being harmed when they needed health services (Ribeiro; Nascimento, 2011; Bispo Junior; Martins, 2012; Lisboa et al., 2016). Accordingly, some of these studies pointed to the need for subjects with a more active, critical attitude and less dependent on institutions (Miwa; Serapioni; Ventura, 2017; Ribeiro; Nascimento, 2011), which seems to depend on a broader institutional and social scenario, which can stimulate awareness and democratic citizenship practice.

The process of participating: building participatory actions

This category is based on the idea that the participation process depends on several factors, not just propositions demanded in the HC already established and in operation. They involve the path that leads to community initiatives and mobilizations in creating or maintaining these councils, seeking what actions would be necessary and transversal to promoting social participation in local contexts.

Regarding the interaction between the Municipal Health Council (MHC) and the LHC, some authors observed the lack of support on the part of the municipal councilors, which could be more participatory in implementing and developing the LHC and mediating with the healthcare managers. These reviewed studies described local councilors as helpless and impotent for not being able to include their demands in MHC meetings, suggesting that social participation in these forums has been co-opted and dominated by healthcare managers (Barroso; Silva, 2015; Lisboa et al., 2016; Lopes; Almeida, 2001; Miwa; Serapioni; Ventura, 2017; Ponte et al., 2019; Tilio, 2014; Vale et al., 2017).

Thus, some studies pointed out this management interference in the HC as authoritarian, bureaucratic decision-making, little publicized, and instituted in a descending way. Therefore, the importance of appropriating the legally created channels of SUS participation by the population is discussed so that its performance does not become limited and fragile (Barroso; Silva, 2015; Oliveira; Dallari, 2015; Jerome, 2018; Pestana; Vargas; Cunha, 2007; Tilio, 2014; Vale et al., 2017; Vale; Lima, 2015). Still in this direction, another aspect approached was the tendency of ideological domination by the management, with users appropriating the discourse of the healthcare managers and becoming dependent on them. In the context of the LHC, the presence of the BHU managers/coordinators at the meetings ended up inhibiting the community from denouncing the problems in the territory (Jerome, 2018; Pestana; Vargas; Cunha, 2007).

It is known that many of the decisions taken in the HC end up not corresponding to the interests and needs of the represented population. In this regard, Barroso and Silva (2015) showed that more than half of the studied municipal councilors either participated little or did not participate in meetings in the PHC of their neighborhoods and that knowing the reality of their community and attending collective spaces would reduce the distance between those people representing a community and those who are represented. Miwa, Serapioni, and Ventura (2017) highlighted the importance of creating mechanisms that facilitate identification between users and representatives.

The studies also discussed that the absence or weakness of community organizations in the neighborhoods and links with other instances gave rise to the creation of forums for exogenous interests (Mittelbach; Perna, 2014; Lisboa et al., 2016; Bispo Júnior; Martins, 2012). Therefore, it is clear that simply institutionalizing a space for social participation is not enough to promote social mobilization and community involvement, bringing up the issue of the representative legitimacy of HC.

The issue of volunteering in the health councilor activity was another point that appeared in one of the studies as a factor of lack of interest in the participation of healthcare users since the attributions developed demand time and dedication, requiring giving up personal tasks in favor of the interest collective, without receiving payment for it (Vale et al., 2017). This is especially important if we consider that a large part of the SUS user population is from the working class, which suffers from unemployment, precarious working conditions, and income (Guibul et al., 2017).

The meeting schedule was also brought up as an impediment to participation, highlighting the difficulty of reconciling the community's activities with the demands of work and family members (Busana; Heidemann; Wendhausen, 2015; Junglos et al., 2019) and also the lack of adequate spaces and resources for meetings (Jerome, 2018). PHS nurses, representatives of the workers' segment, addressed difficulties for them to participate in the HC; one of them was work overload, as participation would reduce their availability for care, in addition to some already working double shifts (Martins; Santos, 2012; Mittelbach; Perna, 2014). Similarly, Domitrovic, Araújo, and Quintanilha (2013) state that professionals are generally not supported in promoting community participation and building social emancipation.

The dissemination of HC deliberations and meetings also appeared in the studies as a fundamental point for the successful construction of social participation in health since the lack of information about the days and times of the meetings, in addition to the lack of transparency about what is deliberated, made it difficult to access and demonstrated that there is no interest in making visible to healthcare users how these spaces work (Domitrovic; Araújo; Quintanilha, 2013; Franchi et al., 2012; Martins; Santos, 2012; Mittelbach; Perna, 2014; Vale et al., 2017).

Varela et al. (2020) highlighted other aspects that facilitate participation when reporting the process of creating a LHC, which was only possible due to the relevant union between FHS professionals and healthcare users. The authors pointed out that this link would have expanded the reach of resolutions of the population's problems in the LHC based on trust and empowerment among the councilors. Varela et al. (2020) also noted that overcoming the initial limitations of implementing the LHC brought the participants closer since sharing anxieties, needs, and claims over time strengthened an identity construction in the researched LHC, providing stronger bonds among the councilors.

Thus, the motivational process for participation encouraged by the health service itself is highly relevant in realizing the community's interest in health issues and building communication bridges that bring professionals and healthcare users closer to the demands of the territories. In this process, two studies highlighted the performance of community health agents (CHA), recognized for their mediating and articulating role between the health team and the community (Varela et al., 2020; Miwa; Serapioni; Ventura, 2017).

Finally, two other studies described unique aspects involved in the participation process. Lisboa et al. (2016) analyzed the case of a municipality that had received many migrants due to the new companies installed there, which tensioned a feeling of not belonging to these forums and the emergence of a conflicting social identity that compromised social participation. Tilio (2014) presents an atypical study of creating a LHC in a penitentiary environment, bringing the difficulties of deliberating in a scenario with authoritarianism as an institutional culture. After the training and implementation of the LHC and with the intensification of demands arising from people deprived of their liberty in the meetings, the penitentiary's management decided to demobilize the space, no longer allowing it to function in conflict negotiations and the search for joint solutions.

Permanent education to strengthen social participation in health

Permanent education was understood by the studies as required for social participation to occur within functions and attributions compatible with the purpose for which these spaces are created, which would allow social actors to act

with greater knowledge symmetry (Busana; Heidemann; Wendhausen, 2015; Jerome, 2018; Junglos et al., 2019; Lopes; Almeida, 2001; Miwa; Serapioni; Ventura, 2017; Ponte et al., 2019; Ribeiro; Nascimento, 2011; Tilio, 2014; Vale; Lima, 2015).

In this sense, both training and permanent education appear as essential tools for the exercise of citizenship and social control, strengthening educational spaces that aim at decision-making that represents the community, forming critical, participatory subjects and multipliers of the ideal of participation (Martins; Santos, 2012; Miwa; Serapioni; Ventura, 2017). Miwa, Serapioni, and Ventura (2017) point out precisely the relevance of training and permanent education with horizontal exchanges of knowledge, so that not only scientific knowledge is validated – which would reinforce the invisibility of the experiences lived by healthcare users in their territories and the widespread understanding that can emerge from there.

Junglos et al. (2019) described, in their study with LHC, that 66% of the participants attended the offered councilor training course. Lopes and Almeida (2001) reported that 49.8% of the councilors in the LHC studied had never participated in education/training courses. Tilio (2014), on the other hand, noted the provision of training for the PDL before the implementation of the LHC to make them multiplier agents and to consider the relevance of understanding the structuring legislation of the SUS in guaranteeing rights and in the functioning of the HC.

Some studies showed an impoverished view of health professionals' role in social participation, as they understood their role only in disseminating, informing, guiding, and making the community aware of the services provided. Many health professionals' representatives in the CS do not seem to claim, together with the population, the improvement of health conditions and, consequently, the conditions of their work (Martins; Santos, 2012; Mittelbach; Perna, 2014). Mittelbach and Perna (2014) claim that this position allows one to assume that, for professionals, only healthcare users have problems to be treated within the scope of HC. In addition, the research registered the lack of stimulus for the representation of the segment of workers in the HC among nurses, which shows the need for a political formation that fosters an awareness regarding the interests and necessities of the class.

Martins and Santos (2012) found in the studied BHU that professionals considered the performance of the LHC to be good only when they supported the decisions coming from the BHU. Therefore, a more critical position on the part of the community was seen as negative by them. In this sense, Ponte et al. (2019) discussed the scarce inclusion of social control in the academic training of health professionals. The nurse-councilors' motivation in the study for social participation came from experiences in student movements, as spaces of first contact with social control, and after entering the universe of PHC in the specific scope of work in the FHS.

Of note, the PHC has been under construction for decades in Brazil and plays a central role for the SUS in providing comprehensive health and quality care to the population, being considered the gateway to the use of health services at all levels of complexity (Guibul et al., 2017). Thus, the proximity and the bond established between professionals and the community become strategic for the qualification of the PHC, mainly in the FHS model. It enables healthcare users to play an active role in the organization of the local health system and build actions to improve their quality of life (Martins et al., 2011).

Another relevant point discussed by the authors of the reviewed studies was the importance of strengthening the expanded notion of health in these spaces and not the simple concept of the absence of disease since, often, the themes of the HC meetings end up being restricted to specific complaints functioning of the BHU – consultations, referrals, medication, among others. However, the studies also identified themes addressed in the LHC meetings that transcended the space of the BHU, such as environmental issues and actions in favor of the community – a good place for garbage disposal, violence, renovation of squares, construction of the network sewage, among others (Oliveira; Dallari, 2015; Domitrovic; Araújo; Quintanilha, 2013; Jerome, 2018; Lopes;

Almeida, 2001; Martins; Santos, 2012; Miwa; Serapioni; Ventura, 2017; Vale; Lima, 2015).

Final considerations

The results expressed by the analyzed studies pointed to different experiences of social participation developed in the territories where the PHC operates, but mainly about the difficulties faced in implementing the LHC. From the categories presented, it was possible to understand that the profile of the health councilors in the studies is varied. However, in common, they already have a participatory history in other spaces. At the same time, the studies stressed healthcare users' low competence to exercise the councilors' role as community representatives, making it essential to foster links with different individuals and groups for a legitimate representation. In addition, the importance of establishing connections between the LHC, the MHC, and other partner instances was emphasized so that the process of implementation and operation of the HC has more significant support and is more successful. The greater motivation and awareness of health professionals to promote and act in these participatory spaces was another relevant point raised by the present study. Finally, expanding the autonomy, empowerment, and social emancipation of the subjects involved in the HC proved to be central to making them less susceptible to interference from healthcare managers or exogenous wills, such as personal interests or those of the private sector.

Added to this scenario, in recent years, are the challenges related to the weakening of spaces for participation and democratization of social relations in a scenario of fiscal austerity, lack of funding for the SUS, and the dismantling of social policies in the country. For example, we cite Decree No 9.759 of April 11, 2019, which extinguished several councils and commissions that made it possible to articulate various instances and actors of civil society. Therefore, based on the findings, we emphasize the need to strengthen and qualify participatory processes in the health field to preserve the health system and Brazilian democracy.

Finally, although the present study has focused on the formally instituted mechanisms of social participation in the PHC context, it is understood that involvement can also occur in various non-formal spaces in the territories. Therefore, establishing relationships between spaces already formally established is relevant to stimulate participation and movements that occur more spontaneously in everyday social relations, paying attention to the micropolitical power of local contexts as spaces for overcoming barriers to social participation and democratic expansion. Thus, it would be essential for new studies to map and discuss the experiences of participation within the PHC that articulate formal and informal spaces.

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