

Participatory management in the Family Health Strategy: reorientation of demand in the light of the Paideia Method

Gestão participativa na Estratégia Saúde da Família: reorientação da demanda à luz do Método Paideia

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ABSTRACT The objective was to describe the construction of a co-responsibility action plan involving managers, professionals and users, aimed at reorienting spontaneous demand in a Family Health Unity, by means of participatory management tools. This was an interventional research study, the action-research type, carried out with a Family Health Strategy team in the municipality of Petrolina (PE). The study involved eleven participants, who were selected using the qualitative representativeness sampling technique, and included three primary care managers in the municipality, four health professionals from the Family Health Strategy involved in the study and four community leaders, representatives of users. The theoretical framework adopted for the analysis of the intervention was the method of analysis and co-management of collectives – the Paideia method. The study revealed the unpreparedness of collectives to act in participatory management, while showing that possibilities of restructuring services are optimized when thought of in a democratic and co-responsible way. It was considered that the main contributions of this research were the awareness and the mobilization of the subjects to act in a participatory way in the planning and management of health problems.

KEYWORDS Family Health Strategy. Health management. Health service needs and demands. Community participation.

RESUMO *Objetivou-se descrever a construção de um plano de ação de corresponsabilização entre gestores, profissionais e usuários, para a reorientação da demanda espontânea em uma Unidade de Saúde da Família, por meio de ferramentas de gestão participativa. Tratou-se de um estudo intervencionista do tipo pesquisa-ação, realizado com uma equipe de Estratégia Saúde da Família do município de Petrolina (PE). Participaram do estudo 11 sujeitos, selecionados pela técnica de amostragem da representatividade qualitativa, sendo 3 gestores da atenção básica do município, 4 profissionais de saúde da Estratégia Saúde da Família envolvida no estudo e 4 líderes comunitários, representantes dos usuários. O referencial teórico adotado para a análise da intervenção foi o método de análise e cogestão de coletivos, o Método Paideia. O estudo evidenciou o despreparo dos coletivos para atuarem na gestão participativa, ao tempo que revelou que as possibilidades de reestruturação dos serviços são otimizadas quando pensadas de maneira democrática e corresponsável. Considerou-se que as principais contribuições deste estudo foram a sensibilização e a mobilização dos sujeitos para atuarem de maneira participante no planejamento e na gestão dos problemas de saúde.*

PALAVRAS-CHAVE *Estratégia Saúde da Família. Gestão em saúde. Necessidades e demandas de serviços de saúde. Participação da comunidade.*

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Introduction

The Family Health Strategy (FHS) is considered to be a means for the expansion, qualification and consolidations of primary assistance, as it enables a re-orientation of the work process, yet with greater potential to deepen into both the principles and the directives of the Unified Health System (UHS – SUS)^{1,2}.

Franco and Merhy² mention the FHS as an attempt for reorganizing the health services, based on the assumption of producing care, the existence of a user-centered work process and receptive relationship, able to create attachment in a productive process that counts on the most relational technologies for users' assistance.

From this perspective, the participatory planning is shaped on the adoption of innovative practices and mechanisms which make popular participation effective and cover a system that includes cooperation, sharing, transparency and social central performance as a means for promoting democratic practices³.

Concerning services, the participatory planning requires widening organizational arrangements that are structured in order to stimulate the production/construction of both individuals and collectives for managing actions and policies practices of social control^{4,5}.

Although still incipient, social participatory spaces have been created in the basic assistance aimed at recognizing individuals able to establish a dialogical interchange of ideas with health services and to enable increasing strategies to fight for a for facing up to local problems. Therefore, widening spaces and claiming for users' and workers' social participation, along with managers, in the process of social planning, is currently a challenge for the FHS participatory planning⁴.

Day after day, FHS teams have also been facing the task of putting on scale both spontaneous and programed demands, as one of the great difficulties in their work process is the need to organize the assistance for priority groups in greater risk and vulnerability, which requires programed medical appointment, yet

without neglecting the spontaneous search for health services and urgent assistance^{6,7}.

Researches report a number of factors that contribute for the increase of spontaneous demand. Some of them have structural origin, such as health units located far from the Health Support Network (HSP/RAS), and Family Health teams that are in charge of a populational contingent that exceeds the number as established by the Ministry of Health (MH). Other factors have cultural nature, historically based on health practices and paradigms⁶⁻⁹.

Rocha⁷ remarks that exacerbated spontaneous demand have been directly interfering on the FHS operation, leading teams to lack putting in place preventive actions to carry on healing interventions and those of prompt assistance. Such inversion of practices leads to increasing preventive pathologies and making chronic diseases more serious, thus reinforcing the binomial health-disease, besides weakening assistance practices based on health prevention and promotion.

In order to avoid an assistance step back, the MH produced instruction guidebooks on how to deal with the spontaneous demand, to support the teams in their work processes^{10,11}.

Araújo and Assis¹² argue that, although built on scientific consensus to guide the FHS workers' performance, the protocols offered by the MH require the users to make a critical analysis and must be adapted to the actual conditions of the population, taking into account the main problems faced up by the community.

Furthermore, the authors stress the need to promote both individual and collective meetings that stimulate the teams' creativity, so that the group may be able to propose adequate responses, focused on individuals, whenever dealing with the social and health needs of that community¹².

Based on this proposal and on the use of dialogue as social praxis, the purpose of the present study is to describe the construction of a co-responsibility action plan to be agreed on by managers, professionals and users, meant

to offer new direction for the spontaneous demand in a Family Health Unit (FHU), using participative management tools, considering limits and possibilities.

Material and methods

This is an interventionist study, the research-action type with qualitative approach, carried out in a Basic Health Unit (BHU) in Maria Tereza Project, located in the municipality of Petrolina (PE) during years 2018 and 2019.

Researches identified as interventionist are intended to assign value to the production of knowledge that might enable new actors to come to make part of the research process and who, by their turn, become co-responsible for both leading and building up the collective knowledge¹³.

Thiollent¹⁴ argues that the research-action is aimed at clearing up problems that carry scientific relevance, by means of groups that bring together researchers, members of the problem- situation and other actors and partners interested in the issue.

A peculiar characteristic of the research-action is the previous existence of an investigative process, once the problem and its variables are either unknown or require further knowledge, besides getting the researcher closer to the reality under investigation¹⁵.

Eleven subjects took part in the study, selected using the sampling technique of qualitative representativity: three were managers responsible for the basic assistance in the municipality; four were health professionals of the Family Health Team (FHT) involved in the study – doctor, nursing technician, Health Community Agent (HCA) and receptionist; and four community leaders, representing the users. It must be remarked that the nurse was excluded from the sample, as she was the leading researcher; and the dentistry team also did not take part in the sampling because it has been replaced during the intervention.

The qualitative representativity sampling

technique deals with some few individuals intentionally chosen considering their relevance as to a specific aspect, that is, their social representativity considering the situation¹⁴.

The research was structured in two moments: the first moment, an exploratory one, and the second moment, one of intervention, aimed at covering all 12 stages proposed by Thiollent, those that generate and guide a research-action.

The exploratory stage included the selection of the subjects, based on their social representativity considering the problem aspects to be studied. The profile diagnosis of the users who spontaneously come to the health service for assistance was elaborated using data collected in secondary sources, reports of the Informatization Strategy of Primary Health Attention (e-SUS APS) and unit's record book of demands; and using primary sources from semi-structured interviews.

The intervention stage was aimed at the presentation of data produced in the exploratory stage, the construction of the theme to be investigated, the problems to be posed, the formulation of hypotheses, the identification of learning needs of the intervention groups and the discussion on formal and informal information. It was conducted by the intervention seminar, which led to the elaboration of the action plan, structured based on directives of the Situational Strategic Planning (SSP).

The theoretical-methodological referential adopted for the analysis of the intervention was the method of analysis and co-management of collectives by Gastão Wagner Campos, known as the Paideia Method (or the Wheel Method)⁴. This reference assumes that management must be a collective task, not monopolized by individuals who count on larger economic and cultural capital. It raises the possibility of reproducing and widening spaces for democratic procedures, able to influence the production of subjectivity of the actors, in an ambiance of reflection, criticism, conflicts, production and transformation. In this sense, it fits the evaluation and management of actions

and behaviors of those who work in teams, its basis of analyses taking for reference thematic nuclei concerning the world and the subject.

Using participatory observation, carried out in both the exploratory and intervention stages – when the researcher did carefully record impressions in a field diary –, the present study analyzed the subjects' behavior and interventionist proposals so as to identify converging and diverging points among those subjects, besides analyses aspects proposed by the thematic nuclei of the method.

At first, final results were not divulged but among the research group. Later on, they were divulged in both social and academic ambiances, by means of reports submitted to groups involved in the project, and information produced by this research were also made public, in accordance with methodological orientations of the research-action.

It must be remarked that the study did respect ethical precepts for researches that involve human beings, according to Resolution by the Ethics Committee of the University to which researches are affiliated, under Nr. 3.203.082.

Outcomes

Describing the intervention seminar and the plan construction for re-orienting the spontaneous demand

The intervention seminar brought together health professionals, managers as local leaders to discuss issues connected to the spontaneous demand at the BHU, and to consensually and democratically come to a proposal of strategies for medical care improvements.

The event included the subjects of the research and collaborators connected to the University of Pernambuco (UPE).

At the first moment, as the seminar was opened, participants were received in a welcome dynamic for socialization, when each

of them enounced his/her name and social representation, and when the group was reminded of how important that meeting would be.

Next a general presentation took place, describing the locality and the health unit: physical structure, population enlisted, health indicators and difficulties of access to other health reference services in the municipality. Data on the exploratory stage of the research were also presented, putting in relief the users' itinerary at the BHU, the number of appointments carried out upon spontaneous and upon programmed demand, remarking que number of individuals who look for the service and leave the unit without receiving either medical or nursing assistance. The profile of the spontaneous demand and the main complaints concerning assistance were also reported.

At that moment some uneasiness took place among the members of the group, and some of them argued that the local government was the one to be blamed for the situation, thus leading the researcher to intervene to calm down the conflict. A sensibilization video was then exhibited, stressing the need for the subjects to be co-responsible in order to solve complex problems¹⁶.

Once interest conflicts were overcome, the research theme was proposed: How to improve the work process at the FHS in Maria Tereza Project? And how to conciliate answering to both the programed and the spontaneous demand?

Following the debate process, mediated by the presentation of data produced during the exploratory stage, problems were posed: demanding services is a cultural issue and has to do with not being acquainted with the work proposed by the FHS; it has to do with the insufficiency of human resources, the infrastructure of the unit and the fragility as to the reception to the spontaneous demand.

The action plan was constructed considering the following hypothesis: what actions can

be agreed on, based on bringing collectives close to each other, in order to organize the demand for health services and to intervene on the problems identified?

Because the group was heterogenous, and as learning needs had been previously identified, a mediation on formal and informal knowings was carried out by collaborator technicians linked to the UPE, who brought

to be discussed theoretical elements about the FHS, its working process, health policies and aspects of participatory management in health.

Given this route, the action plan itself was produced upon democratic basis and produced collective goals agreed on by the subjects, using the Situational Strategic Planning (PES) tool.

The product of that intervention is presented on the tables below:

Table 1. Situational Strategic Planning for the first matrix problem of intervention

THE DEMAND PROBLEM WAS ASSOCIATED TO THE UNAWARENESS OF THE WORK PROPOSAL BY THE FHS AND WAS UNDER CULTURAL INFLUENCE OF THE BIOMEDICAL MOODEL (SURCH FOR EXAMS AND PROCEDURES)	
GOAL/OBJECTIVES:	Specific: Perform communitarian sensibilization as to the FHS; Measurable: Hand out educational leaflets to all domiciles in the locality covered by CHA; Attainable: CHA already used to visit every domicile every month, and could help for this mass sensibilization; Relevant: Population aware could optimize the use of BHU's services and contribute for demand re-orientation; Delay: Start-out within 90 days and continuous permanence.
STRATEGY:	Promote educational and community re-orientation processes in the areas and in waiting room.
PLAN OF ACTION:	Professionals would produce an educative folder or leaflet to meant to orient the community about the purpose of the FHS and operation of th BHU. Management would be responsible for copies to be delivered to the domiciles during CHA's visits and would be used in educative activities in the waiting room by other FHS employees. And also in local activities promoted by communitarian leaders.
RESULTS EVALUATION:	The strategy will be evaluated by the analysis of the reason for going do the BHU, the records of assistance to spontaneous demand and by reports produced by the electronic medical report.
POTENTIALITIES AND FRAGILITIES OF THE STRATEGY: Servants needed for this action would already be available, not requiring new FHS teams to be created. The effect on behavior and culture changes are long term processes.	

Source: The author.

CHA: Communitarian Health Agents.

Table 2. Situational Strategic Planning for the second matrix problem of intervention

THE DEMAND PROBLEM WAS ASSOCIATED TO THE INSUFFICIENT NUMBER OF TEAMS TO RECEIVE THE POPULATION AND WORSENE DUE TO INADEQUATE PHYSICAL STRUCTURE OF THE BHU	
GOAL/OBJECTIVES:	<p>Specific: Enlarge the number of FHT groups and improve the physical structure of the unit;</p> <p>Measurable: Acquire two more teams and create a new BHU nearby;</p> <p>Attainable: Join the BHU off the Program Health Just in Time so as to involve a temporary team to be later changed into a FHT;</p> <p>Relevant: A new team would help carrying out part of the service. Later on, with two teams, the population would be reorganized so as to optimize procedures.</p>
STRATEGY:	<p>At first, improve the physical structure in place; reorganize the population enrolled, following the National Policy for Basic Care, with two more FHS teams nearby; and temporary adherence to the Program Health Just in Time. All those actions in place, the problem would be under control for a while, until new teams are in place and works are concluded.</p>
PLAN OF ACTION:	<p>With municipal funds, renovation would improve the structure, with painting, electric and hydraulic services. Based on the number of users per 25km², two extra teams would be required to the Ministry of Health. A Parliamentary Amendment would raise money to build the second headquarter, a more easily accessible one, and to reshape the first one, at the village. As this would be a long and bureaucratic process, managers would produce a provisional cadaster at the Health Just in Time Program, thus allowing for hiring a new team to enlarge the reception period at the unit, with a reorganization of the users enrolled, unburdening the existing teams.</p>
RESULTS EVALUATION:	<p>The external evaluation tool of the program Access and Quality Improvement (PMAQ) concerning item Observation at the Basic Health Unit would be used to evaluate improvements resulting from this strategy.</p>
<p>POTENTIALITIES AND FRAGILITIES OF THE STRATEGY: Then interest revealed by the managers to put in place and assign priority to this action was a strategy power; and the fragility turned to the political dependence, due to the possibility of delays, as procedures depend on parliamentary amendments and ministerial terms.</p>	

Source: The author.

Table 3. Situational Strategic Planning for the third matrix problem of intervention

THE DEMAND PROBLEM WAS ASSOCIATED TO THE FRAGILITY OF THE RECEPTION	
GOAL/OBJECTIVES:	Specific: Make sure people looking for the service would be well cared for; Measurable: Receive every day all users coming to the unit; Attainable: Select one professional with graduation level to receive exclusively those classified as risk users; Relevant: Check the needs of users who come for care; Delay: 60 days.
STRATEGY:	Doctors and nurses would be responsible, in turns, for the reception and the classification of risk of users who come for spontaneous demand.
PLAN OF ACTION:	In a team meeting with the other professionals, those with graduation level present at the intervention, would organize an assistance agenda in order to have one doctor and one nurse free for the reception, in turns, if necessary, considering vacations or day-off, according to the scale.
RESULTS EVALUATION:	Every three months a research on users' satisfaction would check the efficacy of the strategy adopted. The verification would also take place in demands books and electronic systems of assistance records, and on users who leave without being seen by the doctor.
POTENTIALITIES AND FRAGILITIES OF THE STRATEGY: The office of the professional in charge for the day could be used for reception, risk classification and care procedures, thus avoiding works to open new areas for those procedures. In case of absence of the professional for health problems or other reasons, should there be no professional to replace him/her a technical agent would take that function for the day.	

Fonte: Elaboração própria.

Evaluating the intervention using the Paideia Method

According to Campos⁴, the Paideia Method allows for the analysis of collective actions, based on the interpretation of the practical action by the subject in the world and operating with theme nuclei that refer to both the world and the subject.

Out of the theme nuclei that refer to the world, Campos' method opens room for some considerations on the interpretation of practical actions by the subject: what are the ultimate object and the objectives of the human action? Is the product the only means for analyzing an intervention? What means are used by the subject to get acquainted with and to intervene on a given context? What are the co-responsibility tasks adopted by the subject?

The theme nuclei referring to those subjects

are concerned with their existence worldwide, taking into account their motivations/interests to take part in the intervention; the subjects' ability

to establish bridges with other subjects' interests; the analysis of the powers network, the possibility to exert social control; and the subjects' cultural and ethical references concerning the problem-situation.

Furthermore, Campos⁴ states that the Paideia Method evaluates three criteria that are critical when subjects are organized with interventionist purposes:

1 – The acknowledgement that one of the main objectives of management policies and of the human work is to build up welfare and social justice;

2 – The presupposition that policies, management and work must be also evaluated as to their ability to build the best possible

coefficients of autonomy and freedom for both individuals and institutions;

3 – The ability to assure conflicts resolution and contracts elaboration that involve divergent interests and values, by means of persuasion and negotiation tools.

Considering the above-mentioned, the intervention of the present research was analyzed taking into account the theme nuclei and the criteria as proposed by the Paideia Method.

During the stage of individual interviews, it was also observed that, in principle, the users' motivation to take part in the research had to do with personal interests related to politics. This perception was confirmed in their gestures, behaviors and discussions as the intervention took place. Each communitarian leader showed interest in bringing to his/her own area of activity the professionals of the new FHT to be created, thus suggesting that acquiring a new team would be an individual achievement with power to bargain for social prestige.

However, this stress lost strength as epidemiological data from each area of Maria Tereza Project were made public, and as those numbers were considered, as well as the distance between micro-areas and the possible headquarters of the new FHS – although there is no definition as to its new location. However, a pact was sealed: it must be easily accessible for the community, and must count on the main indicators on health risks and vulnerability.

As to the professionals, strategies suggested by the subjects concerning knowledge and interventions on the situation reflected their cultural and ethical references on the issue. It was noticed that most proposals were elaborated by managers and professionals, probably because the users do not understand their own roles in managing the health services, or yet because they feel like victims in the situations, not considering themselves as co-responsible for the problem.

It was evident the subjects' ability to establish connections with other subjects'

interests, even in contradictory situations involving personal interests and communitarian needs. This was very clear when they were led to step back from previous opinions and accept work proposals that, at the first moment, were not favorable for themselves – for instance, a reception stage before the new FHS could be in place, and the re-dimensioning of the population enrolled, besides the re-consideration of the location for the headquarters of the new team by the users, as mentioned above.

The analysis of the powers network and of the possibility of exerting the social control was just poorly observed in this intervention. Proposals aimed at creating health boards and a sort of 'justice of peace' office were not noticed. In this aspect, the group did only decide on one future meeting for following up the strategies that had been defined.

Discussion

From the strategic angle, planning is the science and the art of governability, and is structured as a set of technical principles, methodological procedures and group techniques, which may be applied in social organizations that aim at situational changes of a problem shared by the subjects¹⁷.

Situational Strategic Planning is a tool developed by Chilean economist Carlos Matus during the seventies, as planning failures were observed when traditional tools were used. It is characterized as a management tool that can accept either adaptations or reformulations of the plan that, according to the situation variables, may prove more adequate for solving complex problems¹⁸.

In this sense, considering the complexity of the problems that might influence the spontaneous demand of the service under study, this tool was the option in order to propose an intervention plan, considering the variables involved, as well as the potentialities and fragilities of each strategy.

Thus, it was acknowledged that the demand issue in health services is closely connected with the non-acquaintance of the FHS work proposal, a behavior that is culturally influenced by welfare practices of the biomedical model, which lead users to relate service rendering to the offer of procedures and clinical exams, not acknowledging the importance of the preventive and health promotion work developed by FHS teams.

Esmeraldo et al.¹⁹ state that the users' comprehension is still dominated by the influence of the hegemonic model, doctor-centered, focused on the illness, the biological and the cure, disconnected from the social context and the understanding of both prevention and promotion.

Considering the above, the intervention team proposed a communitarian sensibilization strategy that involved ascribing managers, professionals and local representatives all co-responsible. The work team would produce an educational material in order to highlight the HFS importance, the services being offered and the assistance flow. This material would be produced using local public financial resources, and would be handed out in waiting rooms, home visits and social actions, by community health agent and by leaders of neighborhood associations. Although the effect on behavior and culture changes are known to be a long-term process, Bittencourt²⁰ argues that the conscientization of the population concerning the FHS objectives and proposals is vital for the organization of the work process.

On the strength of it, the intervention group considered that it would not be possible to reorganize the demand by simply introducing strategies to the work process: considering the population enrolled at that locality, it would be necessary to create two more FHS teams in order to disburden the service. The city administration took the responsibility to enable that acquisition at the Health Department and, by means of a Parliamentary Amendment, funds would be raised for a building more

easily accessible for the population, where the teams would be installed.

Furthermore, professionals and communitarian leaders were in charge of pointing out where that new building should be located, taking into account sociodemographic data and health indicators of each locality, besides monitoring the time scheduled determined by the municipal government. Pinali²¹ remarks that, besides delaying the assistance, the excessive number of people enrolled at the health unit leads to dissatisfaction in the community and personal disturbances for both professionals and users.

Another strategy elaborated by the intervention group meant to re-orient service demand was the optimization of the reception of spontaneous demand based on risk classification, to be carried out by professionals with academic degree (doctor or nurse), in turns: keeping one professional supporting the reception of spontaneous demand would release the others to dedicate continuous care to groups in larger risk and vulnerability. The HM stands for the importance of how users are received to identify the need of assistance interventions, to assure care continuity and to create attachment bonds²².

It must be remarked that even bigger and more important than the construction of the intervention matrix itself was the initiative by the research group of mobilizing and getting closer to groups in order to discuss a social issue, and to propose democratic strategies for solving problems.

Social participation é a doctrinaire principle of the Health Unified System (HUS/SUS) asserted by the Constitution, an incentive for users, managers and professionals to act autonomously, as representatives when managing health services, thus stimulating the practice of both citizenship and co-responsibility²³.

The organization of groups is mandatory for bringing up that principle. Campos⁴ states that the role of organized groups is to produce goods or services that may fulfill social needs. The author argues that institutions and the

society itself must be organized to attend people. Nevertheless, bringing together, in one single purpose, heterogeneous individuals who have different interests and power gives place to a paradoxical polarity: producing usage values that fulfill social needs and ensuring the organization of the subjects.

In order to confront that paradox, Campos⁴ suggests the construction of a new correlation of forces that may reduce power differences among social groups, establishing structures that consolidate more even power situations. One alternative would be the co-management of collectives.

Co-management (or participatory management) is the administration mode that includes the way collectives think and act. Tocci and Costa²⁴ mention that, in order to make co-management come true, one must get acquainted with the institutional reality and create discussion spaces where dilemmas and detritions may be put into context, besides collectively thinking and deciding the work organization, involving managers, users and workers. In this process, it is fundamental sharing previous experiences as to what people know, by means of conversation groups, workshops and meetings, proposing managerial solutions and changes as to the work organization.

In that purpose, the shared management (co-management) allows to recognize, whatever the circumstance, diverging interests between the production agents and the public, enabling as well, despite the conflicts between the logic of production of use values (for instance, social needs and health) and private interests of both the agents and the institutions, that it may be possible to consider all of them as purposes that are legitimate and manageable⁴.

The existence of conflicts in meetings that bring together heterogeneous collectives, with different interests and powers, is inevitable. Mediating such conflicts using techniques of communitarian shared responsibilities is the purpose of participatory management

processes. And this is possible when the FHS field is acknowledged as the space of micro-policies and changes, and when one tries to reduce the imperative of assigning blame that often prevails when subjects with different economic and cultural capital get together to discuss social issues.

Finally, this was considered a valid intervention, as it stimulates the democratic commitment of the participants, and as it allows for the recognition that the final benefit of the action was basically social, not individual. And as it allows the subjects to express their private wishes and interests, yet ensuring interest conflicts to be mediated. Thus, the general co-management criteria as preconized by Gastão Wagner Campos have been observed.

Final considerations

The study shed light on the unpreparedness of collectives to act in a participatory basis when managing the care, as it revealed that the possibilities for re-structuring services are more feasible when thought of in a democratic and co-responsible way.

Transferring responsibilities in management processes tends to be a critical knot in the present work proposal. Therefore, one must stimulate the re-significance of both practices and attitudes, considering that transformations in work processes must be preceded by transformations of the subjects.

That was one of the difficulties in this research: to make clear the importance of having subjects taking part in managerial issues involving health services, demolishing the idea that the responsibility for managing public services belongs exclusively to governmental levels.

Uniting managers, professionals and users to perform this mission is a hard task. Difficulties to conciliate work agendas, public and personal interests are exposed, besides the lack of comprehension of the social role in defending the UHS principles, such as part of

the factors that contribute for this challenge and were experienced in this research.

The limitation of the present study resides on its scope of daily comprehension, which requires a singular and vivid experience, limited to just one health unit. Additional investigations are therefore recommended to evaluate the outcomes of the implementation of the plan elaborated in this analysis and its evidences.

It is expected that the present work may help other HFS teams that also face difficulties in dimensioning the demand, and that it may raise the understanding of the importance of social participation in managing the services, thus stimulating collectives to be continuously organized to solve problems in the health work process.

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Collaborators

Clemente MP (0000-0002-5613-8872)* contributed substantially to the conception, planning, analysis and interpretation of the data. Pinto AGA (0000-0002-4897-1178)* and Martins AKL (0000-0002-9382-1144)* contributed significantly to the critical review of the content. ■

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