Revista Brasileira em Promoção da Saúde
e-ISSN:1806-1230
Original Article
DOI: 10.5020/18061230.2020.10908

# Local health council: formation implementation and difficulties in the Family health Strategy

## *Conselho local de saúde: implantação e dificuldades da formação na Estratégia Saúde da Família*

## *Consejo local de salud: implantación y dificultades para la formación de la Estrategia de Salud Familiar*

**Leilany Dantas Varela**
Municipal Health Department of Milagres (*Secretaria Municipal de Saúde de Milagres*) - Milagres (CE) - Brasil

**Rauana dos Santos Faustino**
Ceará State University (*Universidade Estadual do Ceará*) - Fortaleza (CE) - Brasil

**Consuelo Helena Aires de Freitas**
Ceará State University (*Universidade Estadual do Ceará*) - Fortaleza (CE) - Brasil

**Yana Paula Coêlho Correia Sampaio**
Estácio Medical College de Juazeiro do Norte (*Faculdade de Medicina Estácio de Juazeiro do Norte*) - Juazeiro do Norte (CE) - Brasil

**Rogério Sampaio de Oliveira**
Estácio Medical College de Juazeiro do Norte (*Faculdade de Medicina Estácio de Juazeiro do Norte*) - Juazeiro do Norte (CE) - Brasil

**Antonio Germane Alves Pinto**
Regional University of Cariri *(Universidade Regional do Cariri)* - Crato (CE) - Brasil

**Evanira Rodrigues Maia**
Regional University of Cariri *(Universidade Regional do Cariri)* - Crato (CE) - Brasil

**Maria do Socorro Vieira Lopes**
Regional University of Cariri *(Universidade Regional do Cariri)* - Crato (CE) - Brasil

**ABSTRACT**

**Objective:** To describe the process of implementation of the Local Health Council, formation and difficulties faced, through the view of the counselors, with an emphasis on social participation in the territory of the Family Health Strategy. **Methods:** Study of a qualitative nature, with a critical-reflexive approach. Held in the territory of a Family Health Strategy team in the city of Milagres, Ceará, Brazil, with 22 subjects, users and health workers members of the Local Health Council. The survey took place between February and July 2016, through systematic observation techniques, documentary survey and focus group. Data analysis based on hermeneutics and dialectics was chosen. **Results:** The local problems were the reasons for community participation and mobilization in the implantation and formation of the Local Health Council. The organization and functioning of the council involved users and the health team in practices integrated to the demands and needs of the territory. Community participation, empowerment for citizenship and the joint responsibility of people emerged in the process of local planning of health actions and in the collective confrontation of daily difficulties. **Conclusion:** The changes that occurred in the Family Health Strategy territory with the implementation and formation of the Local Health Council show the potential of this social participation device. The weaknesses in the council's organization underscore the need for encouragement, support and support at the base of the Unified Health System.

**Descriptors:** Health Planning; Participative Planning; Family Health Strategy; Health Councils.

***RESUMO***

***Objetivo:*** *Descrever o processo de implantação do Conselho Local de Saúde, incluindo a formação e as dificuldades enfrentadas, por meio da visão dos conselheiros, com ênfase na participação social no território da Estratégia Saúde da Família.* ***Métodos:***



**Received on:** *05/08/2020*
**Accepted on:** *07/03/2020*

*Estudo de natureza qualitativa, com abordagem crítico-reflexiva, realizado de fevereiro a julho de 2016 no território de uma equipe da Estratégia Saúde da Família no município de Milagres, Ceará, Brasil, com 22 usuários e trabalhadores de saúde integrantes do Conselho Local de Saúde. A pesquisa ocorreu por meio de técnicas de observação sistemática, levantamento documental, entrevista semiestruturada e grupo focal. Emergiram três categorias: Contextualidades na implantação do Conselho Local de Saúde; Formação do Conselho Local de Saúde frente às situações cotidianas da comunidade: necessidades de saúde, participação e renovação; Dificuldades enfrentadas no processo de organização do Conselho Local de Saúde.* ***Resultados:*** *Os problemas locais foram os motivos para a participação e a mobilização da comunidade na implantação e formação do Conselho Local de Saúde. A organização e o funcionamento do conselho envolveram usuários e equipe de saúde em práticas integradas às demandas e necessidades do território. A participação comunitária, o empoderamento para cidadania e a corresponsabilização solidária das pessoas emergiram no processo de planejamento local das ações de saúde e no enfrentamento coletivo das dificuldades cotidianas.* ***Conclusão:*** *As mudanças ocorridas no território da Estratégia Saúde da Família com a implantação e formação do Conselho Local de Saúde evidenciam a potencialidade desse dispositivo de participação social.*

***Descritores:*** *Planejamento em Saúde; Planejamento Participativo; Estratégia Saúde da Família; Conselhos de Saúde.*

***RESUMEN***

***Objetivo:*** *Describir el proceso de implantación del Consejo Local de Salud incluyendo la formación y las dificultades afrontadas a través de la opinión de los consejeros con énfasis en la participación social del territorio de la Estrategia de Salud Familiar.* ***Métodos:*** *Estudio de naturaleza cualitativa de abordaje crítico-reflexivo realizado entre febrero y julio de 2016 en el territorio de un equipo de la Estrategia de Salud Familiar del municipio de Milagres, Ceará, Brasil, con 22 usuarios y trabajadores sanitarios del Consejo Local de Salud. La investigación se dio a través de técnicas de observación sistemática, recogida de documentos, entrevista semiestructurada y grupo focal de los cuales emergieron tres categorías: Los contextos para la implantación del Consejo Local de Salud; Formación del Consejo Local de Salud ante situaciones del cotidiano de la comunidad: necesidades de salud, participación y renovación; Dificultades afrontadas en el proceso de organización del Consejo Local de Salud.* ***Resultados:*** *Los problemas locales han sido la causa de la participación y la movilización de la comunidad para la implantación y la formación del Consejo Local de Salud. La organización y el funcionamiento del consejo han involucrado usuarios y equipos de salud en prácticas integradas según las demandas y las necesidades del territorio. La participación comunitaria, el empoderamiento para la ciudadanía y la co-responsabilidad solidaria de las personas llevaron al proceso de planeamiento local de las acciones de salud y el afrontamiento colectivo de las dificultades del cotidiano.* ***Conclusión:*** *Los cambios ocurridos en el territorio de la Estrategia de Salud Familiar con la implantación y la formación del Consejo Local de Salud han evidenciado la potencialidad de ese dispositivo de participación social.*

***Descriptores:*** *Planificación en Salud; Planificación Participativa; Estrategia de Salud Familiar; Consejos de Salud.*

## INTRODUCTION

Popular participation and social control in health, among the principles of the Unified Health System (*Sistema Único de Saúde - SUS*), are very relevant from a social and political point of view, as they are organized with the guarantee that the population will participate in the formulation and control process of public health policies. In this context, the institutionalization of spaces for community participation in the health service's daily life stands out by guaranteeing the participation in planning to face the prioritized problems, and the implementation and evaluation of actions, a process in which popular participation must be guaranteed and stimulated[1].

The Federal Constitution of 1988[2] guaranteed the management of SUS as a responsibility shared by the Union, states, and municipalities with the autonomy of each federated entity being respected and with decisions based on a joint representative consensus, between the state and the citizens[3].

The National Health Council (*Conselho Nacional de Saúde - CNS*), in line with the councils of states and municipalities, defines the general guidelines for planning in all levels of management and establishes national priorities for health care[4]. The CNS is the participatory space that issues the main regulatory documents of the Health Councils (*Conselhos de Saúde - CS*), among them: the guidelines for creating, reformulating, structuring, and functioning, according to federal legislation[5].

Municipalities, based on local needs, guidelines established by Municipal Health Councils (*Conselho Municipal de Saúde - CMS*), and state and national priorities, elaborate, implement, and evaluate the municipal planning cycle[4]. In some locations, there are Local Health Councils (*Conselho Local de Saúde - CLS*), which are linked to a Health Unit and comprised of representatives, users in their area of coverage, workers from the service itself, and local SUS managers[5]. The CLS is encouraged by the teams of the Family Health Strategy (*Estratégia de Saúde da*

*Família - ESF*) and aims at participatory governance of the community in facing their local problems. Difficulties in functioning are related to the training of counselors and support for the operationalization of activities[6].

The ESF integrates Primary Health Care (*Atenção Primária à Saúde - APS*), which represents the main gateway to SUS and the communication center of Health Care Networks (*Redes de Atenção à Saúde - RAS*). It establishes the coordination of care and orders the actions and services available to users. Every day, the bonds between family health teams and users are maintained in the actions performed. In the local planning, the situational health analysis, the prioritization of risks and vulnerabilities, and the community mobilization to improve the quality of life stand out[7,8].

From the perspective of local and participatory health management in the ESF scenario, planning can be used as a management tool in team and community involvement. The union of people involved in the participatory deliberation of actions is effective in finding solutions to problems that arise in the daily lives of health services[9]. Investment in processes that allow the adoption of effective measures becomes necessary. Thus, it is possible to expand the possibilities of intervention in situations considered inadequate, such as the reduction of inequalities identified by management concerning the citizen's life and health conditions[10].

Full social control requires the expansion of information, communication, and community participation initiatives in solving demands and needs[8]. The CLS is configured as a less bureaucratic space and can be considered a practice of citizenship, with the potential to generate social changes and improve the living conditions of the community[11]. In accordance with the National Health Promotion Policy, expanding the participation of the population with collective representation in the territory enhances the effectiveness of the actions, without exempting the responsibility of the Brazilian State. Network initiatives, in an intersectoral and participatory way, favor the autonomy of local actors to plan strategies for daily coping and act in the transformation of social reality[12].

In this study, the hermeneutic-dialectic method is used for data analysis, which presupposes an understandable and dialectical investigation, with attitudinal criticality in the research context. Therefore, the dialectic allows a look at the different meanings and senses, in their multiple interests or contextual positions. The recognition of language as an expression of similarities and differences in social and historical determination is the understanding that nothing is built outside this process[13]. In this context, it is relevant to expose local management experiences that have led to problem-solving movements to improve the population's health and quality of life. Thus, the study aims to describe the implementation process of the Local Health Council, its formation, and the difficulties faced, through the counselors' view, with emphasis on social participation in the Family Health Strategy territory.

## METHODS

This study is of a qualitative nature[14], with a critical-reflexive approach whose data collection occurred from February to July 2016. The study scenario is located in the area covered by an ESF health unit in the municipality of Milagres, located in the south of the state of Ceará, Brazil. Primary care coverage is 100%, with 13 family health teams.

The community chosen for the research is located in a rural area, with the only CLS in the municipality in operation. In it, the health team linked to the territory is composed of community health agents (CHA), nurse, doctor, dental surgeon, nursing technician, oral health technician, driver, pharmacy attendant, reception attendant, and two general services nursing assistants. The number of families registered is 627, and the population enrolled in the ESF-I is 1,936 people. The CLS has a non-equal composition, formed by 26 councilors, with 18 users (69%), mostly representatives of community associations, church, school, and guardianship council, in addition to eight health workers (31%), composed of a surgeon -dentist and a nurse, five CHA and a nursing technician[15].

For the selection of participants, the following inclusion criteria were used: being a user or health worker who is part of the family health team in the territory under study and a member of the CLS. Of the possible participants, four did not meet the inclusion criteria. Among the users, two were unable to participate because they were in other activities at the time of collection and in the health team, the nursing technician, for being in another activity, and the team nurse, for being the main researcher of the study. Thus, the sample consisted of 22 participants, members of the CLS, who received an invitation to be part of the study after learning about its objectives and the relevance of their participation.

The techniques of systematic observation[16], documentary survey[17], semi-structured interview[14], and focus group were used[14]. The planning and organization were guided by the use of scripts and themes, to address multiple possibilities of participation of the study members and their information about the implementation and operation of the CLS.

The field diary was used to record the information and notes of the researcher's impressions[16]. In this study, the following points were observed: organization of the CLS, planning, and development of activities, integration of

the health team with the community, and integrated and co-responsible resolution of problems. Ten CLS meetings and community events were observed. Documentary information was collected at the health unit and the CLS, as well as in the minutes of ordinary and extraordinary meetings. For this research, the data from October 2013 to June 2016, are about the implementation of the CLS, composition, functioning, representation, and social mobilization.

In this study, the focus group was applied in three sessions: one with health workers and two with users. The sessions took place at the family health unit and the headquarters of the farmers association. The conduct of focus groups by researchers was guided by the theme in question. Initially, the semi-structured interview was applied, which contained questions related to the identification of participants (sex, age, and education) and professional performance (occupation, professional category, and length of experience in the ESF, in the case of health workers).

Continuing the session, an image was used with colorful puppets holding hands, representing the diversity of the social context, and discussions started with a reflective moment. The thematic questions were established in sequence, with subjects on the process of implementing the CLS, meanings of the process for the participants, and the results of the CLS in the daily life of the community, based on their training and difficulties faced.

It should be noted that all 22 members of the CLS participated in the discussion of the theme, the organization, and structuring of the fieldwork and the construction of the question script. Empirical data were recorded by recording the speechs of each group. Each session lasted around 45 to 60 minutes. In line with the assumptions of the focus group technique[14], the moderator conducted the moments of presentation, reflection, and discussion, indicating the activity and promoting the debate among the participants. The observer took notes related to the group interaction.

The stage of data analysis began with the transcriptions of the recordings, followed by exhaustive reading of the transcribed material. And so, the analysis progressed, made concrete by an articulated movement between the empirical and theoretical sources, peculiar to the hermeneutic-dialectic method[14]. The intertwining between theory and practice generated three categories of analysis: Contextualities in the implementation of the Local Health Council; Formation of the Local Health Council in face of the daily situations of the community: health needs, participation, and renewal; Difficulties faced in the organization of the Local Health Council.

The study is in line with ethical principles involving human beings, following Resolution No. 466/2012 of the National Health Council[18]. The research was approved by the Research Ethics Committee of Universidade Regional do Cariri (CEP / URCA), under Opinion No. 953.830. Participants signed the Free and Informed Consent Form. To maintain anonymity, they were called Focus Group 1, 2, and 3 to represent the technique and session; the participants were assigned the nomenclature of the groups of users and health workers and the numbers 1 to 16 and 1 to 6, respectively. The speeches highlighted in this focus are those that are most significant for the themes in question, the rest is in the research report and under the guardianship of the researchers.

## RESULTS AND DISCUSSION

In this space, the identification data of the study participants will be presented, followed by the analysis categories that emerged from the study.

### Participant identification data

The CLS is represented by users and workers on the ESF team. The composition of the sample group represented by the users had 16 participants, four men, and 12 women, aged between 23 and 65 years, with an average of 37 years.

As for education, two had an elementary school level, 12 had a high school, and two had higher education. Regarding the occupation, seven performed household activities, two were traders, two were artisans, and, still, in a unitary manner, farmer, self-employed, teacher, and tutelary counselor. Only one participant was retired.

From the group represented by the health workers, six people participated: the dentist and five CHA, the group consisting of three men and three women. They were aged between 32 and 65 years, with an average of approximately 42 years. As for the time working in the ESF, the professionals had a minimum of six years and a maximum of 25 years. Regarding the level of education, two had higher education and four had high school.

### Contextualities in the implementation of the Local Health Council

Experiencing SUS and its identity reaffirms the search for its principles through the struggle and institutional integration, and one of them is the implementation of CLS. In this category, the historical contextualization of the CLS implementation is expressed in the narratives and information about the institutional events that were transversal in the process. Highlighting, the municipal health conferences, the National Program for the Improvement of Access

and Quality of Primary Care (*Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica - PMAQ-AB)*[19], and the motivation by the ESF team.

The 14th Municipal Health Conference, in 2011, with the theme "Everyone uses SUS! SUS in Social Security, Public Policy and Heritage of the Brazilian people" triggered the need for community representation at the event[20]. The motivation of the health team had the encouragement of the municipal management from 2011, with the realization of local pre-conferences of health in the municipality territories. The following narratives express the participation of people in the community and the impulse to the process of community participation in the ESF:

> *"I was invited because of the Pre-Conference on Health at the Site [referring to the name of the Site] and also because of having only one counselor there. As we say, at the top of the [name of the area], there is. At the bottom, and there was no one up there, it gets overwhelmed for just one counselor, so I was invited and I'm participating and acting ". (Focus Group 3 - User 02)*

The previous statement tells how the path of user involvement in social control took place, as well as the necessary motivation. A motivational process is a tool that acquires social value for those who integrate the planning and evaluation actions. With the participation stimulated by the health service, the efficiency and effectiveness of public management are guaranteed[21].

To outcome community interest in health issues, the local pre-conferences aroused feelings of belonging by establishing communication bridges that brought people closer to the territory and encouraged the desire to participate, as shown in the following statement:

> *"I entered participating in a meeting [Local Health Pre-Conference], there at the friend's club [refers to the friend's name], when our colleague nurse [refers to the name] launched the invitation for anyone who wanted to be part; I volunteered to be part of it, I was analyzing, thinking and seeing that it was a good, serious and constructive movement and I want to stay until the day God wants". (Focus Group 2 - User 01)*
>
> *"I was invited by the ACS [Refers to the name of the ACS], since then I felt motivated, I started to enter this fight; since then I feel very gratified and proud of the service that we do in our community and we are setting an example for several communities there ". (Focus Group 2 - User 04)*

The union between ESF professionals and users was pertinent in initiatives that instigated the construction of citizen autonomy. The bond between people expanded the scope of solving population problems in the CLS, with increased confidence and empowerment among counselors[5].

The integration between professionals and users so powerful at the local level can be an example of municipal health conferences. However, the formats of the conferences can be rethought, since they can distance the population, as it presents a difficulty to understand complex languages and deliberations that escape from their daily lives[22,23].

The incentive and planning for the consolidation of the CLS relied on the assessment tools of SUS, mainly the community mobilization. In its evaluation modules, PMAQ-AB was attentive to social participation. This stage aroused in the ESF team interest in encouraging participatory planning of actions in the territory:

> *"I remember, as soon as the nurse [referred to name] saw it at the PMAQ-AB, she called us first and asked if it was feasible to happen at [refers to the name of the ESF unit], and we gave every support, we invited people, asked for people pass it on to the whole community, invited people who were interested of their own free will to participate to help more in making improvements to the community, asking for the participation and co-participation of users ". (Focus Group 1 - Health worker 04)*
>
> *"We met with PMAQ, we met with the community." (Focus Group 1 - Health worker 03)*

For the CLS organization, the operational process of the Access and Quality Improvement Program (PMAQ) was rescued by evaluating the infrastructure of ABS services and the work process of the teams and user satisfaction[19]. The PMAQ-AB has been an important agent of change based on the self-assessment of the health team, with the potential to improve the quality of services, work processes, and actions in the territory[24].

**Formation of the Local Health Council in face of the daily situations of the community: health needs, participation and renewal**

In this category, the actions for organizing the CLS are presented, which were organized by the supportive hands of the community. With the opening to participate in the resolution of problems, Health Promotion actions in

the territory became effective. The SUS renewal took place through the mobilization of users and health workers in search of social transformation.

The CLS organization had as a parameter the legislation that regulates the Municipal Health Council (CMS)[25]. However, there is a difference in the parity composition, since, in CLS, the largest number of members is represented by users (69%,18). This composition was agreed between the health team and the community, as it better represents the community segments:

> *"How do we organize the Local Health Council: we do the same as the city, taking all segments, and the nurse [refers to the nurse's name] quickly organized the council. It came about like this: we got together as a team and called the community together, choosing a segment in each area, and forming the council ". (Focus Group 1 - Health worker 05)*
>
> *"There was a meeting there at [the name of the research territory], and there they told us if we were going to participate in this Council, each representing its own segment, wasn't it? It was, and we accepted it, starting the Council; I remember that was it ". (Focus Group 2 - User 06)*

The representative categories of the CLS were composed of the population diversity of the territory. The counselors felt fully identified by their living, working, and health conditions:

> *"We saw that we needed to get community participation. They are represented: young people, women, men, pregnant women, mothers, the elderly, hypertensive people, diabetics, the disabled, farmers, traders, representatives of churches, the farmers' union and local schools ". (Focus Group 1 - Health worker 01)*
>
> *"And I, the representative of agriculture, I was the farmer; [Refers name] represented the trader". (Focus Group 2 - User 02)*
>
> *"The first meeting was at the Community Association, which I stayed as a young person [representative] and [referred to name] stayed as a [representative] of the union". (Focus Group 2 - User 09)*

It was necessary to overcome the superficial and, almost always, bureaucratic form of popular participation in health. The population needed to get involved, become part of the process, seek and feel their belonging in SUS management. Integrated participation between community and health professionals enables the success of community interventions, as it ensures that the problems detected are effectively valued by the communities[23].

It is relevant to highlight that the motivation of the ESF team has a direct relationship with the way health professionals work. Although the recommendations of the municipal management and evaluation of the PMAQ-AB occurred in other teams in the municipality, only in the researched district the CLS was organized. In practice, the work process is enhanced by the initiatives provided by subjects who are affected by the participatory construction of SUS[26]. It is important to note that the scenario is not always favorable. It presents challenges, breaking ties, demands from the community, and management. The new health practices demand interest, articulation, and zeal for the necessary measures aimed at balancing care and bureaucratic functions[27].

The perspective of popular action in the study's local council proved to be active in the sense of working for a common good. Despite the legal provision for participatory democracy and social control in SUS, citizen participation in municipal councils is limited by the passive representation of their representatives. The attributes of institutional motivation for participation and proximity to problems can make participatory management effective[28].

It is necessary to recognize informational and cognitive asymmetries that can interfere in the deliberative quality. The dialogues between the counselors are expanded with the provision of training courses, participation in conferences, implantation of the ombudsman and thematic commissions to deepen the debates[29].

Regarding the degree of professionals' involvement, CHAs stand out as determinants for the construction and mobilization of users, resulting in expressive participation in the localities. It is expressed that the participation of micro-areas contributed to the consolidation of CLS:

> *"My community participates in a greater number of meetings because I work on the importance of their participation, and they are more committed to the movement, so much so that they ask that the meetings take place in [name of locality], because they donate even more, as the colleague said". (Focus Group 1 - Health worker 02)*

In its daily work, the ACS acts directly in the areas of the territory. Mediation between knowledge and practices of the health team and the community is a process of multiple senses and meanings. The recognition of fpopular knowledge established in care, disease prevention, and health promotion relationships strengthens the effectiveness of ESF actions, which links to it[30].

The composition of the council showed a flow of participation and renewal of people. The CLS allows the mobility of counselors, whether in a pre-health conference or an ordinary meeting:

> *"Then we had the pre-conference, where there was a change of participants, of advisers and also there, of this change, the board revived, and also, together with these new advisors, many demands arose". (Focus Group 1 - Health worker 06)*
>
> *"It was getting more counselors, people to participate, and new counselors, to further increase the strength of the Council". (Focus Group 1 - Health worker 01)*
> *"It is increasingly strengthening, new members are coming, following the work, we are achieving good things both for the community and for the work itself". (Focus Group 1 - Health worker 01)*

The composition of the CLS is decided during district pre-conferences, with a mandate that lasts until the other Municipal Health Conference. When there is a need to renew the directors, the CLS itself decides. Thus, representativeness is assured, while support can be fragile in contexts of participatory apathy and isolation of the representative[31].

The critical look at the implementation of the CLS ensures and improves the instrument of participation through the development of strategies and contributes to positive indicators. The following are considered: the realization of financial autonomy; encouraging the strengthening of social representation entities; promoting actions to increase the visibility of health councils; and the creation of a routine for approval and disclosure of resolutions[32].

**Difficulties faced in the organization of the Local Health Council**

The speeches identified daily difficulties during the implementation of the CLS. In the beginning, there was a low adhesion to the community organization movement, due to the low credibility of the population. At the time they were ready to function, the counselors managed to mobilize the community with solidarity initiatives and the persistence of actions, as expressed in the narratives:

> *"We think it was difficult to get here, we went through difficulties. For us to form this council there were some difficulties, such as on the day we meet. We set up a meeting and people sometimes came, sometimes they didn't come, always without that credibility, they didn't believe in the advice, a little discouraged, but we activated the seed and continued anyway, until [it] got better and more people entered, and improved, until we are here. Today, the council is much bigger in activities, everyone with a willingness to do something". (Focus Group 1 - Health worker 06)*
>
> *"Despite the difficulties over the years, many things have already been accomplished, many, many campaigns [of donation among the residents] have been carried out, which have already been successful". (Focus Group 3 - User 02)*

The limitations were overcome due to involvement in difficult situations in the community, such as the campaign to obtain a wheelchair for a user. Solidarity campaigns bring people together in their attitudes to each other, by listening to the wishes, needs, and demands, as well as by co-responsible interventions and also by monitoring public management[33].

In this process of identity construction of the CLS, it was possible to consolidate a representative place by facing internal and external demands. As time passed, the mobilization process involved participation and provided maturity in the group of conselors, considered more cohesive and stronger:

> *"I also think that it is a very important thing that has been happening during these meetings, that we have been doing monthly, it may even be that it has not been monthly every life, because we sometimes stopped doing one or the other". (Focus Group 2 - User 06)*
>
> *"Sometimes, there are some things that give some difficulties, but sometimes not. So I already participated in several campaigns, such as the wheelchair, which we managed to do, we walked there in [refer to the name of the community], I walked with the other counselor, at the time it was just me and her, we walked the [refers to the name of the community], then I walked in the city, also with the other counselors". (Focus Group 3 - User 03)*

With the initiative of the CLS, it appeared a possibility to consolidate the attention and strategic planning in health[5-7]. Intending to strengthen the SUS, CLS involved initiatives that promoted health and increased visibility on social needs. In its operation, the CLS has become a space for dialogue, construction of knowledge, and development of resolutive actions for the well-being of people. In line with the National Health Promotion Policy, it carried out health planning with attributes of social justice, democracy, and citizenship[34].

The limitation of this study surrounds its focal proposition, as it is a unique experience lived locally. It is suggested, for further studies, the expanded analysis for other aspects, such as care impacts on SUS management.

## FINAL CONSIDERATIONS

The implementation of the CLS, as well as representative training, was established based on community involvement with the local health situation and the encouragement of the ESF team in the territory. The representativeness of users was multiple and coincided with the diversity of social actors and their daily relationships.

The motivation of the ESF team was based on making the social participation process effective. We highlight the involvement with local issues and soupportive attitudes, which brought people together in the transformation of their reality. Social control enhances health actions in their planning, management, and evaluation.

## CONFLICTS OF INTEREST

The authors express that there are no conflicts of interest.

## ACKNOWLEDGEMENTS

To the users and health teams of the Unified Health System (SUS) of Milagres, Ceará.

## CONTRIBUTIONS

**Leilany Dantas Varela**, **Rogério Sampaio de Oliveira** and **Antônio Germane Alves Pinto** contributed to the preparation and design of the study; the acquisition, analysis and interpretation of data; and the writing and / or revision of the manuscript. **Rauana dos Santos Faustino**, **Consuelo Helena Aires de Freitas** contributed to the writing and / or revision of the manuscript. **Yana Paula Coêlho Correia Sampaio**, **Evanira Rodrigues Maia** and **Maria do Socorro Vieira Lopes** ontributed to the acquisition, analysis and interpretation of data; and the writing and / or revision of the manuscript.

## FUNDING G SOURCE

Ministry of Health. Oswaldo Cruz Foundation (FIOCRUZ). Northeast Family Health Training Network (RENASF).

**Study based on the dissertation:** Local health council in the territory of the family health strategy: participation, involvement and community solidarity. Dissertation (Professional Master's in Family Health - MPSF), belonging to the Northeast Family Health Training Network - RENASF. Regional University of Cariri, Crato, Ceará. 2016. 120p.

## REFERENCES

1. Ministério da Saúde (BR), Secretaria de Gestão Estratégica e Participativa. A construção do SUS: histórias da Reforma Sanitária e do Processo Participativo, Secretaria de Gestão Estratégica e Participativa. Brasília: Ministério da Saúde; 2006.
2. Senado Federal (BR). [Constituição (1988)]. Constituição da República Federativa do Brasil 1988 [Internet]. Brasília: Senado Federal; 2016 [accessed on 2020 Mar 27]. Available from: https://www2.senado.leg.br/bdsf/bitstream/handle/id/518231/CF88_Livro_EC91_2016.pdf
3. Arcari JM, Barros AMA, Rosa RS, Marchi R, Martins AB. Perfil do gestor e práticas de gestão municipal no Sistema Único de Saúde (SUS) de acordo com porte populacional nos municípios do estado do Rio Grande do Sul. Ciênc Saúde Colet [Internet]. 2020 [accessed on 2020 Mar 27];25(2). Available from: https://www.scielosp.org/article/csc/2020.v25n2/407-420/
4. Ministério da Saúde (BR). Manual de planejamento no SUS, Ministério da Saúde, Fundação Oswaldo Cruz [Internet]. Brasília: Ministério da Saúde; 2016 [accessed on 2020 Mar 27]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/articulacao_interfederativa_v4_manual_planejamento_atual.pdf
5. Zermiani TC, Freitas RS, Pessali HF, Ditterich RG. A participação dos conselhos locais de saúde na contractualização de metas na atenção primária à saúde: a experiência de Curitiba, PR. Interações (Campo

Grande) [Internet]. 2019 [accessed on 2020 Mar 27];20(4). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1518-70122019000401115&lang=pt

6. Jerome JS. Participatory governance in the context of local health councils: interviews with six local health council presidents in Northeastern Brazil. Saúde Soc São Paulo [Internet]. 2018 [accessed on 2020 Mar 27];27(3). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902018000300740&lang=pt.
7. Ministério da Saúde (BR). Portaria n.º 2.436 de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília: Ministério da Saúde; 2017 [accessed on 2020 Mar 27]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
8. Oliveira EM, Felipe EA, Santana AS, Rocha IH, Magnabosco P, Figueiredo MAC. Socio-historical determinants of care in the Family Health Strategy: a user perspective in the rural area. Saúde Soc São Paulo [Internet]. 2015 [accessed on 2016 Ago 12];24(3):901-13. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902015000300901&lng=en&nrm=iso
9. Figueiredo IDT, Torres GMC, Cândido JAB, Morais APP, Pinto AGA, Almeida, MI. Planejamento estratégico como ferramenta de gestão local na atenção primária à saúde. Rev Fam Ciclos Vida Saúde Contexto [Internet]. 2020 [accessed on 2020 Mar 18];8(1):27-38. doi: 10.18554/refacs.v8i1.3873
10. Fonseca BMC, Braga AMCB, Dias EC. Planning occupational health interventions in the territory: a participatory experience. Rev Bras Saúde Ocup [Internet]. 2019 [accessed on 2020 Abr 13];44:e33:1-9. doi: 10.1590/2317-6369000015018
11. Busana JÁ, Heidemann ITSB, Wendhausen ÁLP. Participação popular em um conselho local de saúde: limites e potencialidades. Texto & Contexto Enferm [Internet]. 2015 [accessed on 2015 Out 23];24(2):442-9. doi: 10.1590/0104-07072015000702014
12. Pinto MB, Silva KL. Promoção da saúde no território: potências e desafios dos projetos locais. Esc Anna Nery [Internet]. 2019 [accessed on 2020 Jun 25];23(1):e20180282. doi: 10.1590/2177-9465-ean-2018-0282
13. Taquette SR. Análise de dados de pesquisa qualitativa em saúde. Actas: Investigação Qualitativa em Saúde. CIAIQ2016 [Internet]. 2016 [accessed on 2020 jun 25];2:524-33. Available from: http://proceedings.ciaiq.org/index.php/ciaiq2016/article/view/790/777
14. Minayo MCS, Deslande SF, Gomes R. Pesquisa social: teoria, método e criatividade. Petrópolis: Editora Vozes; 2016.
15. Ceará. Documento 1: Livro Ata do Conselho Local de Saúde do Rosário – 2013 a 2016 do Município de Milagres – CE. 2016.
16. Flick U. Introdução à Pesquisa Qualitativa. 3ª ed. Porto Alegre: Artmed-Bookman; 2009.
17. Cellard A. A análise documental**.** In: Poupart J, Deslauriers JP, Groulx LH, Laperriere A, Maye R, Pires A. A pesquisa qualitativa enfoques epistemológicos e metodológicos [Internet]. 3 ed. Petrópoles: Vozes; 2012 [accessed on 2020 Jun 25]. p. 295- 316. Available from: file:///C:/Users/mende/Downloads/ANDRE_CELLARD_-_A_analise_documental._p.pdf
18. Ministério da Saúde (BR). Diretrizes e normas regulamentadoras da pesquisa envolvendo seres humanos: resolução nº 466/12, nº 112, Seção 1, pág. 59 [Internet]. Brasília: Ministério da Saúde; 2012 [accessed on 2020 Jun 25]. Available from: https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf
19. Seus TL, Silveira DS, Tomasi E, Thúme E, Facchini LA, Siqueira FV. Structure for the work and composition of Family Health Support Unit teams: national survey – Program for Improving Primary Health Care Access and Quality (PMAQ), 2013*. Epidemiol Serv Saude. 2019;28(3):2018510.
20. Ministério da Saúde (BR). Conselhos de saúde: a responsabilidade do controle social democrático do SUS [Internet]. 2ª ed. Brasília: Ministério da Saúde; 2013. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/conselhos_saude_responsabilidade_controle_2edicao.pdf
21. Sabioni M, Ferreira MAM, Reis AO. Racionalidades na motivação para a participação cidadã no controle social: uma experiência local brasileira. Cad EBAPE.BR [Internet]. 2018 [accessed on 2020 abr 13];16(1). doi: http://dx.doi.org/10.1590/1679-395155420

22. Ricardi LM, Shimizu HE, Santos LMP. As Conferências Nacionais de Saúde e o processo de planejamento do Ministério da Saúde. Saúde Debate [Internet]. 2017 [accessed on 2020 Abr 01];41(3). doi: 10.1590/0103-11042017s312

23. Sousa FAMR, Goulart MJG, Braga AMS, Medeiros CMO, Rego DCM, Vieira FG, et al. Estabelecimento de prioridades em saúde numa comunidade: análise de um percurso. Rev Saúde Pública [Internet]. 2017 [accessed on 2020 Abr 1];51(11). doi: 10.1590/S1518-8787.2017051006460

24. Uchôa SAC, Martiniano CS, Queiroz AAR, Bay OG Jr, Nascimento WG, Albuquerque IV, et al. Inovação e utilidade: avaliação Externa do Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica. Saúde Debate [Internet]. 2018 [accessed on 2020 Abr 1];42(spe1):100-13. doi: 10.1590/0103-11042018s107

25. Presidência da República (BR). Lei n.º 8.142, de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde – e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências [Internet]. Brasília: Presidência da República; 1990 [accessed on 2020 Abr 1]. Available from: http://www.planalto.gov.br/ccivil_03/leis/L8142.htm

26. Andrade RS, Caldas LBN, Falcão MLP, Goes PSA. Processo de Trabalho em Unidade de Saúde da Família e a Educação Permanente. Trab Educ Saúde [Internet]. 2016 [accessed on 2016 Ago 16];14(2):505-21. Available from: https://www.scielo.br/scielo.php?pid=S1981-77462016005002101&script=sci_abstract&tlng=pt

27. Santos ROM, Romano VF, Engstrom EM. Vínculo longitudinal na Saúde da Família: construção fundamentada no modelo de atenção, práticas interpessoais e organização dos serviços. Physis [Internet]. 2018 [accessed on 2020 Abr 02];28(2):280206. Available from: http://www.scielo.br/pdf/physis/v28n2/0103-7331-physis-28-02-e280206.pdf

28. Barddal FME, Torres RL. Efetividade da participação cidadã nos conselhos municipais de Curitiba. Rev Bras Gest Urbana [Internet]. 2020 [accessed on 2020 Abr 03];12. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S2175336920200001002 03&lang=pt

29. Bortoli FR, Kovaleski DF. Efetividade da participação de um conselho municipal de saúde na região Sul do Brasil. Saúde Debate [Internet]. 2019 [accessed on 2020 Abr 3];43(123):1168-80. Available from: http://www.scielo.br/pdf/sdeb/v43n123/0103-1104-sdeb-43-123-1168.pdf

30. Dantas DSG, Silva MRF, Torres RAM, Oliveira LC, Pinto FJM, Sampaio RMM. Training of community health agents in popular education: involvement in the production of care in the Family Health Strategy. Motri [Internet]. 2018 [accessed on 2020 Abr 13];14(1):157-63. Available from: http://www.scielo.mec.pt/pdf/mot/v14n1/v14n1a21.pdf

31. Bispo JP Jr. Advances and Challenges of Institutionalized Participation in Brazil's Health System. Rev Crít Ciênc Soc [Internet]. 2018 [accessed on 2020 Abr 13]:(117):99-122. Available from: http://www.scielo.mec.pt/pdf/rccs/n117/n117a06.pdf

32. Rocha MB, Moreira DC, Bispo JP Jr. Conselho de saúde e efetividade participativa: estudo sobre avaliação de desempenho. Cad Saúde Pública [Internet]. 2020 [accessed on 2020 Abr 03];36(1):00241718. Available from: http://www.scielo.br/pdf/csp/v36n1/1678-4464-csp-36-01-e00241718.pdf

33. Miranda AS, Moreira AEMM, Cavalcanti CGCS, Bezerra FM, Oliveira JC, Rezende R. Practical discourses about events, decisions processes and effects of Health municipal conferences in Brazil. Interface (Botucatu) [Internet]. 2016 [accessed on 2020 Abr 13];20(58):559-71. Available from: http://www.scielo.br/pdf/icse/v20n58/1807-5762-icse-1807-576220150300.pdf

34. Malta DC, Reis AAC, Jaime PC, Morais OL Neto, Silva MMA, Akerman M. O SUS e a Política Nacional de Promoção da Saúde: perspectiva resultados, avanços e desafios em tempos de crise. Ciênc Saúde Colet [Internet]. 2018 [accessed on 2020 Jun 25];23(6):1799-809. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232018000601799&lng=en

**First author's address:**
Leilany Dantas Varela
Secretaria Municipal de Saúde de Milagres
Rua José Miguel de Figueiredo, S/N
Bairro das Missionárias
CEP: 63250-000 - Milagres - CE - Brasil
E-mail: leyla_nurse@yahoo.com.br

**Mailing address:**
Rauana dos Santos Faustino
Universidade Estadual do Ceará
Av. Dr. Silas Munguba, 1700
Bairro: Itaperi
CEP: 60714-903 - Fortaleza - CE - Brasil
E-mail: rauanafaustino21@gmail.com

**How to cite:** Varela LD, Faustino RS, Freitas CHA, Sampaio YPCC, Oliveira RS, Pinto AGA, et al. Local health council: formation implementation and difficulties in the Family health Strategy. Rev Bras Promoç Saúde. 2020;33:10908.