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SHARED MANAGEMENT: POPULAR PARTICIPATION AS A STRATEGY RENEWING THE WORK PROCESS OF HEALTH PROFESSIONALS

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Jefferson Nunes dos Santos
Federal Institute of Education, Science and Technology of Pernambuco (IFPE) - Pesqueira Campus Pesqueira-PE
http://lattes.cnpq.br/2830045079244372

Vanessa de Carvalho Silva
Federal Institute of Education, Science and Technology of Pernambuco (IFPE) - Pesqueira Campus Pesqueira-PE
http://lattes.cnpq.br/1740764268132146

Cláudia Fabiane Gomes Gonçalves
Federal Institute of Education, Science and Technology of Pernambuco (IFPE) - Pesqueira Campus Pesqueira-PE
http://lattes.cnpq.br/1530461337501494

Kleber Fernando Rodrigues
Federal Institute of Education, Science and Technology of Pernambuco (IFPE) -Pesqueira Campus Pesqueira-PE
http://lattes.cnpq.br/5404409205728691

Janaína Mendes Lopes
State University of Bahia - UNEB
Garanhuns-PE
https://lattes.cnpq.br/0684236904747482

Luciane Patriciana da Silva Santos
University of Pernambuco (UPE)
Palmares-PE
http://lattes.cnpq.br/1937119126104218

Miqueline Correia de Melo
University of Pernambuco (UPE). Nossa Senhora das Graças Nursing School (FENSG) Recife-PE
http://lattes.cnpq.br/2094753634793284

Maria Eduarda Oliveira Vilela
Federal University of Pernambuco (UFPE). Department of Nutrition. Garanhuns-PE
https://lattes.cnpq.br/9726905557192502

Camila Souza Granja
Federal University of Pernambuco (UFPE). Pernambuco School of Dentistry. Recife-PE
http://lattes.cnpq.br/9378275139005979

Thalia Gabriela Maria da Silva
Pernambuco School of Public Health (ESPPE) Garanhuns-PE
http://lattes.cnpq.br/7028385010653954

Manuele Tavares de Melo
University of Pernambuco (UPE). Nossa Senhora das Graças Nursing School (FENSG) Recife-PE
http://lattes.cnpq.br/7886241012959110

Deborah Silva Vasconcelos dos Santos
State University of Health Sciences of Alagoas (UNCISAL) Garanhuns-PE
http://lattes.cnpq.br/6856591977903508

Abstract: Objective: To describe how popular participation has contributed to the renewal of the work process according to the perception of Primary Health Care nursing professionals. Methodology: A descriptive study with a qualitative approach, developed with professional managers from twelve Family Health Strategies in the municipality of Pesqueira-PE, between May and September 2019. Results: Three categories of analysis were structured: Knowledge of Public Policies that reinforce popular participation in health services, Weaknesses in health services that impact on the work process of nursing professionals and Perception of professionals about their work process when including popular participation in their daily practice. Final considerations: Popular participation has demonstrated irrefutable advances in the development of public policies that converge directly with the type of work developed by the professionals who assist them. However, in recent years, this protagonism has diminished, thus creating a margin for political measures that violate constitutional rights to be disseminated throughout society, making it possible to practice care work based on quantitative variables of the care offered, rather than its quality.
Keywords: Popular participation; Health professionals; Family Health Strategy.

INTRODUCTION

Popular participation in the planning and execution of health actions has always been a widely debated topic in legislation related to the Unified Health System (SUS), as it is considered a fundamental pillar for maintaining democratic social control since its consolidation promoted by the contribution of legislative and civil segments, during the 8th National Health Conference in 1986 (SILVA *et al.,* 2019).

Therefore, in theory, the SUS has a sharing of powers in which professionals, managers and users are co-responsible for guaranteeing

and improving health rights, especially those related to access to services and their affordability (LEAL; MELO, 2018).

However, what is widely disseminated in practice is the exercise of a verticalized system, in which society contributes little to decisions health actions that involve its own socio-cultural context, especially at the Primary Health Care (PHC) level, given the more constant and routine preventionpromotion and health education actions (ALMEIDA *et al.,* 2020).

The reasons for the existence of this fragility in the exercise of what the legislation on popular participation advocates are variable and permeate contexts of professional qualification, working conditions, technical, structural and material resources, as well as the scrapping and stiffening of the health system, to the extent that it restricts its health actions to only achieving government goals of quantitative variables, while disregarding, to varying degrees, the qualitative aspects that cover an individual and their societal reality (HOPPE *et al.,* 2017).

With this in mind, this article aims to describe how popular participation has contributed to the renewal of the work process according to the perception of PHC nursing professionals.

DEVELOPMENT

Work is a practice that has been part of human history since the earliest civilizations. As humanity evolved and grew in numbers, the act of working came to be conceived as a mode of socialization, endowed with the ideology of carrying out a certain function or work activity in common with other people, constituting as an act of establishing power relations, policies and the cultural and economic development of a given society (PANIAGO, 2020).

With technological advances during the Industrial Revolution, work became closely linked to the production of a product for use by the masses. Therefore, it was precisely during this period in history that great thinkers such as Max Weber, Henry Ford, Henri Fayol and Frederick Taylor developed their administrative theories, which still have repercussions today in the production systems of different companies, including health institutions such as hospitals, clinics, Emergency Care Units (UPA's) and Family Health Strategies (ESF) (BERTOL *et al.,* 2017; MORORÓ *et al.,* 2017).

In the health field, the various organizational theories have undergone adaptations to suit the singularities present in this area. One of the main ones was related to the conceptions of raw material, product and user, which differ from the meanings present in the sphere of business administration (PERUZZO *et al.,* 2020).

For Administrative Sciences, the raw material is a raw product that has not yet undergone manufacturing or industrial processing to give rise to the product that will be marketed to the consumer. In the field of Health Sciences, on the other hand, there are no tangible goods, i.e. both the raw material and the product offered are health care, directed at users (SORATTO *et al.,* 2020).

This care is present in the daily practice of all health professionals. However, it is most evident in the actions carried out by professionals in the nursing team, because their characteristic is the continuous and uninterrupted provision of care aimed at re-establishing user's well-being or reducing discomfort with their clinical situation to an acceptable level (LEAL; MELO, 2018). In addition, health is a construct of a diversity of determinants and conditioning factors, and nursing professionals have a wide range specialties that encompass this diversity. Therefore, professional practice legislation that legitimizes it and establishes the attributions and rights of this class (SILVA *et al.,* 2019).

Because of this, some of the most common pieces of legislation that govern the care practice of nursing professionals are Law 8.080/1990, which regulates the guidelines,

objectives and attributions of health services and workers as a whole; and the Nursing Code of Ethics, established by Resolution 564/2017 of the Federal Nursing Council, which specifically outlines the attributions of the nursing team in care and management spaces, in addition to legally covering them as an essential labor class in the provision of care to the elderly. health (DA-SILVA, 2016).

In the case of PHC, the professional practice of the nursing team is regulated by Ordinance 2,436 of 2017, which establishes the National Primary Care Policy (PNAB). This policy states that nursing professionals should develop activities aimed at preventing and promoting the health of the population assigned to the unit, through health education actions (LUCAS; NUNES, 2020).

In addition, this ordinance also emphasizes the importance of preserving the autonomy of health professionals who work with the community on a daily basis, in developing inclusive strategies for the population and managing the service, which differs widely from the various levels of health care. However, it is still emphasized that even with this freedom of action, these professionals must have skills that permeate the field of care, administration, teaching, research and political participation (PERUZZO *et al.,* 2020).

As you can see, the duties of the nursing team are extensive and, even though the ESF is characterized as a low-complexity health care system, there are factors that significantly interfere in the execution of this team's work process (BARRETO; ALMEIDA; SOUTO, 2018).

However, to mitigate these weaknesses, the PNAB reinforces a strategy that has a high capacity for mitigation. Over the years, popular participation in contributing to the planning of health actions has proved fundamental to the empowerment of users of the health system, by placing them as promoters and defenders of their right to access quality health and to maintain their complete well-being (ALMEIDA *et al.,* 2020; HOPPE *et al.,* 2017; MELO; SILVA; FIGUEIREDO, 2018).

In light of these issues, it can be seen that the practice of nursing professionals is still undergoing constant improvement. , the acquisition and development of new strategies aimed at improving the work process are fundamental, especially for PHC professionals, as they are the ones closest to the population and the ones who can most effectively strengthen popular participation in health services.

METHODOLOGY

This is a descriptive study with a qualitative approach, carried out with health professionals who manage the ESF's in the municipality of Pesqueira - PE, which has a total of 13 ESF's in the urban area.

The inclusion criteria consisted : professionals who were in the position of management of the ESFs. The exclusion criteria were: professionals who were not in full charge of their job, due to absence on medical certificates, vacations or leave during the data collection phase; and ESFs located in rural areas, due to the difficulty in accessing these places. In addition, the sampling method chosen was non-probabilistic for convenience.

Data was collected from twelve professionals who met the above criteria between May and September 2019. It should be noted that one professional was unfit, as he was on sick leave.

The data was collected in the form of interviews, which were conducted using a semi-structured script drawn up by the authors themselves based on the literature in this study, which aimed to address the following variables: sociodemographic data; knowledge of public health policies aimed at popular participation in health services; and the professional's perception of their work process with the inclusion of popular participation in the service.

The interviews took place by prior appointment by telephone and in a closed environment of the interviewees' choice, lasting an average of 18 minutes. It should also be emphasized that the interviews were audio-recorded for later transcription of the answers in their entirety, according to the participants' agreement.

The data was analyzed using Bardin's Content Analysis (2011), as this technique is constantly improved methodologically, which allows the authors to carry out all the steps inherent to it objectively and critically, as well as delimiting their findings into analytical categories that can be found in the participants' speeches objectively or subjectively.

Therefore, the stages carried out in the analysis were: pre-analysis, marked by the completion of data collection and the beginning of data coding according to its homogeneity, completeness, representativeness and relevance in line with the objectives and hypotheses present in the research; exploration of the material, the end of coding represented by the selection of context units, to finally categorize them according to their semantics, syntax, lexicon or discursive structure present in the participants' speech; and results, characterized by the conformity of the interpretations present in the elements of the communication exercised between interviewee and interviewer.

With regard to ethical precepts, this study is in line with Resolution 510/2016 of the National Health Council (CNS), as it was accepted under opinion number 3.557.049 of the Ethics and Research Committee of the Belo Jardim Teaching Autarchy (BRASIL, 2016).

RESULTS AND ANALYSIS

After analyzing the data, it was possible to structure the results into four central categories: Characterization of the participants; Knowledge of public policies that reinforce popular participation in health services; Weaknesses in health services that impact on the work process of nursing professionals; and Professionals' perception of their work process when including popular participation in their daily practice.

However, for confidentiality purposes, it should be noted that each participant will be given the letter "P" and an Arabic number from one to twelve when excerpts from their answers are shown.

CHARACTERIZATION OF THE PARTICIPANTS

Of the twelve participants interviewed, ten (83.3%) were female and eight (66.7%) were self-declared brown. All the interviewees who were in management positions in the ESF were nursing professionals with higher education and an average of 11.25 years of training in this area.

In addition, eight (66.36%) had a specialization or master's degree related to PHC, and had been working at this level of health care for an average of 5.9 years. However, despite this length of time, only one (8.3%) had an employment contract via a public examination, while eleven (91.7%) worked under a contract with the City Council.

KNOWLEDGE OF PUBLIC POLICIES THAT REINFORCE POPULAR PARTICIPATION IN HEALTH SERVICES

Popular participation in the planning of health actions as a public policy, despite having gained greater visibility in relation to the managers of the various services only in recent years, has been idealized since the promulgation of the Federal Constitution (FC) in 1988, with the existence of the Health Councils, which act as deliberative collegiate bodies, in addition to serving as an interconnection between society and various governmental spheres (ARAÚJO *et al.,* 2018; GOHN, 2019).

The aim was to include society in the planning, control, inspection and execution of health actions, in order perpetuate an equitable and democratic system in which health was a social construct for all parties involved (ROCHA; MARTINS; FARIAS, 2020).

This idealism proved to be essential for the population to empower itself and seek, through its demands, a health system in which people with lower socioeconomic conditions could at least treat their illnesses, which led to the emergence of the SUS (ARAÚJO *et al.*, 2018).

When asked about the existence of public policies that they used to guide their community care practices, the professionals who were most assertive were P8, P9 and 12, as shown in the excerpts below:

> "We base ourselves directly on the Ministry of Health (MoH), on the guidelines, on what the Ministry recommends. So we work on these guidelines together with the Municipal Health Department and we carry out our work" (P8).

> "The Family Health Program (PSF), which is the main thing, right? The PNAB also guides us and the SUS itself, the practices of the SUS" (P9).

> "The primary care booklet for hypertensive and diabetic patients and the PNAB" (P12).

As far as the other participants are concerned, there were some inconsistencies in their answers, since they confused public policies and government programs that guide their professional practice with the care services and structures provided by the ESF, as in the examples below:

> "It's the monitoring we do with this patient. Blood pressure monitoring, right? Hypertensive patients, diabetics [...] When we can, we always do the glucose test [...] the Hemoglobin Test (HGT). We're monitored by the nutritionist from the Family Health Support Center (NASF), which is the support center for the PSFs, and we monitor the weight, height and Body Mass Index (BMI) of these patients [...]" (P1).

> "There are some services offered to the population [...] we have an outpatient clinic, where we nurses refer these patients to the cardiologist that we have here in the municipality [...] there's a pediatrician [...] there's also an orthopedist [...] and also the rapid tests that are carried out at the Testing and Reception Center (CTA). If the patient comes here and needs a referral to the CTA, we refer them to these services. And there are also the ultrasounds that we already receive a spreadsheet for the month from the secretariat, so that the patient can be scheduled from here" (P3).

Furthermore, on this issue, there were professionals who focused only on the existence of government programs that set targets to be met, as can be seen in the following excerpt:

> "We are always guided by the Program for Improving Access and Quality (PMAQ) together with the Electronic Citizen Record (PEC) [...]" (P5).

In the context presented, it is possible to infer a limitation in the professionals' knowledge of the existence of public policies that emphasize participation popular. In addition to those mentioned by the professionals, there is also legislation that came after the emergence of the SUS, which reinforces, at different levels, the inclusion of the community in issues related to public health, such as Law 8.142/90, which determines community participation in Participatory Budgeting (PB), Municipal Health Councils and Conferences; and Law 12.527/11, which guarantees citizens the right to access and transparency of information on the actions of managers and managers of public services (SANTOS *et al.*, 2020a).

It is also possible to mention Ordinance No. 2,135, of September 2013, which guides the management and administration of the SUS with the use of three basic documents, such

as the Health Plan, Programming and Annual Health Report. In conjunction with this ordinance, there is Federal Law 141/2012, which emphasizes the role of councils in evaluating and overseeing the actions of managers, including giving them the right to veto the annual report, as well as to appraise and approve the annual health plan and program (RICARDI; SHIMIZU; SANTOS, 2017).

Therefore, given that the participants have worked for a considerable time in PHC, which works strongly with community inclusion, it was expected that they would have knowledge of these laws. However, only two (16.6%) mentioned knowing any of the examples cited, as shown in the excerpts below:

> "We have these health conferences, which help a lot, you know? So [...] if these conference meetings, the monthly health council meetings, were really put into practice, right? It would improve a lot" (P6).

> "I know about health councils and conferences" (P10).

As we have seen, the existence of legislation is of the utmost importance in ensuring that rights and duties are enforced. Therefore, knowing them becomes mandatory for all individuals who make up a society. However, the low level of autonomy that some health professionals have regarding the history and legislation that guide their care practices is something that deserves attention (XIMENES-NETO *et al.,* 2019).

Since 1978, some literature has presented certain patterns of knowledge that relate to professional practice in nursing. In total, there are six standards, but the central focus of this discussion is White's (1995) explanation, which added the standard of socio-political knowledge (ESCOBAR-CASTELLANOS; SANHUEZA-ALVARADO, 2018).

This latter knowledge, although related to the nursing category, can be appropriate for any individual who is a manager or manager of a service. Since it portrays the autonomy, governability, leadership and social representation that people in positions of decision-making power should possess (ALMEIDA *et al.,* 2020).

This idea is attributed to the idea that individuals in these positions must have knowledge related to their work process, so that their actions can be fully consolidated. Therefore, the presence of weaknesses in health professionals' knowledge of the legislation that governs their work expresses the flaws present throughout the Brazilian health system (PÉREZ-JÚNIOR; DAVI; GALLASCH, 2019).

WEAKNESSES IN HEALTH SERVICES THAT IMPACT THE WORK PROCESS OF NURSING PROFESSIONALS

When asked about the weaknesses that interfere with the work process of nursing professionals, the answers varied due to the realities of each ESF, which are different from one another. It is therefore inevitable that there will be differences between the answers, since each participant's perception is unique.

In general, the responses basically focused on aspects related to the fragility of the supply/maintenance of some services, the number of professionals to provide specific services to the population, the shortage of medication in stock to be distributed to a high number of people, among others, which can be seen in the excerpts below:

> "The aim of primary care is primary prevention, in which 85% of the solutions are provided here. And in reality there are services that we don't have here and that need to be referred. The doctor refers a patient to the UPA [...] to a cardiologist or an orthopedist. Then what happens? We don't get a response from them! We don't have a counter-referral! So the weakness we find is this counter-referral, which I think is happening in several cities here" [...](P1).

> "I could say that there will always be difficulties, in one detail or another, but nothing

> that can't be overcome. For example, a car for home visits. We won't always have a car for home visits provided by the Health Department, but thats not the reason why we won't be able to carry out home visits. So we need to get to the patient to develop this service" (P2).

> "The only weakness is that people always complain about transportation, because many bedridden people can't, right? And we wanted that there was transportation for the doctor to visit, because he doesn't visit in his own car. We go on foot, but the doctor doesn't, so that's what makes it difficult for us to get the doctor to assess this bedridden patient, it's transportation" (P6).

> "What we miss the most is when we give some kind of medication to the community and the municipality doesn't have it or it's out of stock, so [...] There isn't this medication that I can say exactly, but once in a while, there's always going to be a shortage of something in terms of medication" (P3).

> "Look, material [...] Sometimes it's not enough because of the demand and the transfer from the Ministry of Health, for example: rapid testing, which we should do on pregnant women and their partners, so we have a smaller number of rapid tests that we should do in the unit and we have to refer them to the CTA for them to do" (P4).

Delving deeper into the reality of PHC, the pattern of operation of the units is governed by the system of government targets, which significantly interfere in the work process that the professionals develop.

Associated with this, the literature also points to the existence of poor organization and logistics of services, low institutional support, insufficient training on legislation and limited continuing education actions, focused only on government goals, as central points for the weakening of the work process and disarticulation of the Health Care Network (RAS) (FERREIRA; GONÇALVES; DIAS, 2018; MENDES, 2010).

This context is also compounded by the training that these professionals receive, given that, even today, higher education health institutions use a curriculum with few legislative and managerial updates, so as to focus their curriculum on mostly technical and assistance actions, which does not fully prepare the professional for the context of political protagonism in the community (ALMEIDA *et al.*, 2020).

However, professionals should not just be blamed for the weaknesses in their care practices. Regardless of the area in which they work, health professionals deal with long working hours on a daily basis, so their activity has a strong tendency to focus on maintaining a standard pre-established by health institutions (SANTOS *et al.*, 2020b).

In addition, because the professional practice of this labor class is strongly linked to political issues, be they health or social, especially in small and medium-sized municipalities, it is understandable that there are actions that weaken the sharing of power between the community and the professionals.

When asked about this, the participants said that the practice of constant relocation from one ESF to another during changes in political administrations interferes considerably with their work process, as seen in the following excerpts:

> "I've been to all of them. Because when one mayor comes in, he takes it out and puts it in another place, then another one comes in and takes it out and puts it in another place. So it certainly, without a doubt, generates interference" (P2).

> "Yes, because when we arrive at a unit, in a neighborhood, we try to maintain a positive bond with the community, so as soon as we are relocated, transferred, we break this bond and have to do it all over again in a new community and a new health unit" (P3).

It is the duty of health professionals to take political action in defense of society's health rights, especially those who work constantly with the community, as in the case of ESF professionals. Because of this, a relationship between professionals and the community based on trust and mutual bonds is essential for sharing information and actions (FERREIRA; GONÇALVES; DIAS, 2018).

However, the presence of a strong sense of clientelism in Brazilian politics makes this link impossible to varying degrees. Often, especially in small and medium-sized municipalities, political coalitions between the managers of the various public services are common, which make it possible, with each change of political administration, to reallocate all the managerial positions of the mayor's choice (COSTA; MÉLLO; NOGUEIRA, 2018).

This practice has a significant impact on the professionals' work process, since all their actions developed jointly with the community are stopped in favor of an alliance between municipal leaders to perpetuate their influence, instead of prioritizing the permanence and improvement of the working conditions that the professionals develop in the community in which the ESF they manage is attached (ARAÚJO *et al.,* 2018).

PROFESSIONALS' PERCEPTION OF THEIR WORK PROCESS WHEN INCLUDING POPULAR PARTICIPATION IN THEIR DAILY PRACTICE

When the participants were asked how community participation contributes to the planning of health actions aimed at their own community, the answers, although affirmative, exposed a reality that contradicts what is established in current legislation.

As a result, it was found that participation occurs sporadically rather than continuously, as can be seen in the following excerpts from the participants' speeches Next:

> "We've been doing the forum for over four years now, and we invite the community to take part, to tell us what needs to be improved, right? And in these questions and answers that they put, we send them to the health department. It's been two years since the last forum, always when a new administration starts, but regularly every four years" (P1).

> "It's already happened, then they contributed well, then it was more about scheduling exams, scheduling appointments, it was last year, that we gathered the community and asked for their opinion, what improvements they wanted more. It's not a monthly thing, you know? Because for them to come we needed an association, because that's what was going to establish a link, but to organize this as a post we can't, because the demand for me is too great" (P2).

> "No, we don't work directly in this way, only when we do that city event that involves the Health Council, which is the Municipal Health Conferences, where we invite the community, we pass it on, we reinforce the importance, but not here at the Basic Health Unit (UBS)" (P3).

> "It contributes! They always take part! Usually these meetings happen more when there are conferences, they are more interested in coming" (P5).

> "No. When the community participates, it's in the municipal health plan (forum). First we invite the general community, then we determine some members of the community, about 5 members, and this happens every 4 years" (P9).

All these situations contribute to professionals opting for more vertical actions, even though they are aware of their duty to include the community as protagonists of their self-care. Because when this process is not questioned by individuals, it becomes easier to plan, control and execute health actions, and thus all decisions are left exclusively to the multi-professional team and the interests of their political managers (MENDONÇA *et al.,* 2018).

In this regard, some studies point out that shared management is often fragmented on purpose, with the use of actions that exclude the community in a subjective way, such as the omission of information, the use of constant technical terms that make it difficult for civil society to understand what is being discussed, the distribution of ghost positions, and the agglomeration of demands under the pretext of discussion during health conferences, as provided for in Law 8.142/90 (ARCARI et al, 2020; MEDEIROS *et al,* 2017; MENDONÇA *et al.,* 2018).

However, as emphasized above, these weaknesses are not specific to a single agent. For the interviewees, the community still has a low understanding of their duties as users of the system (HOPPE *et al.,* 2017).

In this way, the professionals also emphasize that, despite constantly trying to include the community and make them more participatory in these actions, the refusals and indifference are recurrent, as can be seen in the following excerpt:

> "You always have to call them, they hardly ever participate of their own free will" (P11).

Therefore, when asked how the participants understood popular participation and how it could contribute to the work process that professionals carry out in order to help them establish adequate social control, the answers were:

> "We can't work without the people. Because [...] We have to make them aware that it has to start with them wanting to help us, because without the people and without the Community Health Agents (ACS), we won't get very far. You're overloaded and so you don't know things, you're just one person, and how do you take care of almost 3,000 people, right? So the community is there to help us" (P3).

> "Yes, they'll interact with us, right? Both they and we have to have that exchange of participation, in social control too, let's put it this way [...] let me give you an example [...] like with dengue fever, we pass the information on to them, they pass the information on to us and this exchange of information makes them more careful about where they live" (P4).

> "They are the users of the health service, so [...] our actions really have to be geared towards their needs, if they are here with us, if we get the community to participate, and we listen to their demands and needs, our execution will be more successful, because it won't be according to what I think, it will be according to what they need" (P5).

> "Absolutely. Because the community is the basis of the SUS, without the community, without community participation, the SUS doesn't exist" (P11).

Professionals, in general, rely on the community's adherence and protagonism to exercise more incisive social power in demanding improvements in health, given that the oppression of state power is sovereign at the municipal level and suppresses the possibilities for them to make changes to the local reality on their own, without exposing themselves to the risk of retaliation from the political system (ALMEIDA *et al.,* 2020; HOPPE *et al.,* 2017; MELO; SILVA; FIGUEIREDO, 2018).

However, without the active and organized participation of community members, whether in a council or residents' association, the force needed for social transformation loses its meaning and importance, so as to preserve a status quo of inequalities in which all those involved only make losses, whether they be labor or social (MELO; SILVA; FIGUEIREDO, 2018).

It can therefore be seen that the professionals' work process has no limits when associated with effective community participation, with the proper sharing of power relations between the actors involved and the strengthening of a healthy bond.

Finally, when the participants were asked about their considerations for possible solutions or interventions that could transform their work process with the full inclusion of the community in the sharing of some health actions, the answers were:

> "I think strategies should be devised to make people feel that this is important, if it doesn't affect their health and their lives in some way, they won't be interested. So I think strategies should be devised to make them feel the need to be present at the UBS to deal with these health issues" (P3).

> "Allowing, suddenly, meetings to take place with the community, with the community representative, so that the needs, contentments and discontents can be shared, as we've been working on, I think that's the way to go" (P4).

Although these statements are relevant and pertinent, it can be seen that they are actions that are already provided for in the legislation cited in this study, once again reinforces how professionals have a socio-political role that is less than ideal (ESCOBAR-CASTELLANOS; SANHUEZA-ALVARADO, 2018).

In the midst of this disorder, it is clear that popular participation has the capacity to reshape not only the work process of health professionals, but also the entire system and subsystems present in Brazilian public policies. However, for this to happen, it is necessary for the population to play an active role in maintaining democratic and equitable social control (ALMEIDA *et al.,* 2020; HOPPE *et al.,* 2017; MELO; SILVA; FIGUEIREDO, 2018).

FINAL CONSIDERATIONS

Based on the above, it is possible to explain that social participation has brought changes with a very high impact on society. However, it can be seen that this protagonism has diminished over the years, which has allowed oppressive measures to be disseminated throughout society.

As well as providing care and management, PHC professionals' work is intrinsically linked to educating the community about their rights and duties. Therefore, as they carry out their role, professionals develop a sociocritical mentality, which encourages people in the community to become more protagonists in the community health or political aspects, with a focus on social transformation, a priori, at the local level.

As a result, the population gains a voice in the decision-making spaces for actions that have direct and indirect repercussions on their lives, so that they can determine the measures that best suit their needs. In this way, professionals gain more than active participation in their ESFs, they gain allies with the capacity to expand their health actions to invaluable degrees.

By including popular participation in assisting health professionals in their actions, the development of increasingly empowered and autonomous professionals is established, encouraging them to oppose the traditional work regime determined by Taylorism, since their actions are now based on ethical-legal, technical-scientific and theoretical-philosophical precepts that drive them to be defenders of public health, as well as promoters of human well-being.

Therefore, by following this premise, by unifying the actions of these actors, it becomes possible to guarantee universal access, comprehensive care, as well as timely and agile resolution, together with the preservation of autonomy, this being an initial milestone in a new restructuring of the work process of these professionals, with high potential for resolving various weaknesses in the Brazilian health system.

Furthermore, it should be noted that this study expresses the specific reality of the urban area of the municipality of Pesqueira-PE. It is therefore essential that further studies are carried out with a wider territorial scope, in-

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cluding rural communities and districts of the municipality. In this way, it will be possible to trace, from a comparative perspective, how the work of health professionals in management positions in the ESF is carried out, contributing to the expansion of studies on inclusive measures and shared management with members of the community, as agreements and disagreements are established between the results indicated by this study.

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