

## CONCEPÇÕES, PRÁTICAS E PERSPECTIVAS DE AÇÕES DE SAÚDE COLETIVA: ÓTICA DE ARTICULADORES DA ATENÇÃO BÁSICA

### CONCEPTIONS, PRACTICES AND PERSPECTIVES OF COLLECTIVE HEALTH ACTIONS: OPTICS OF BASIC ATTENTION ARTICULATORS

### CONCEPCIONES, PRACTICAS Y PERSPECTIVAS DE ACCIONES DE SALUD COLECTIVA: ÓPTICA DE ARTICULADORES DE ATENCIÓN BÁSICA

Lina Karina Bernal Ordoñez<sup>1</sup>, Cássia Irene Spinelli Arantes<sup>2</sup>

#### RESUMO

**Objetivo:** analisar o desenvolvimento de ações de saúde coletiva em municípios do estado de São Paulo, sob a perspectiva de articuladores da atenção básica. **Método:** pesquisa do tipo descritiva, com abordagem qualitativa, realizada com dez articuladores da atenção básica. Para a coleta de dados, utilizou-se a técnica de entrevista semiestruturada e as falas foram submetidas à análise de conteúdo na modalidade temática. **Resultados:** emergiram quatro categorias temáticas – concepções de saúde coletiva; contextos que desfavorecem o desenvolvimento de ações de saúde coletiva; contextos que favorecem o desenvolvimento de ações de saúde coletiva; e propostas para o planejamento e desenvolvimento de ações de saúde coletiva na atenção básica. **Conclusão:** há diversos desafios para a prática da saúde coletiva na atenção básica, dentre eles, a falta de reuniões de equipe e o fato de alguns gestores municipais de saúde terem dificuldade para se comunicar e dialogar com as equipes da área. O agente comunitário e o coordenador da atenção básica foram identificados como importantes aliados para o fomento de práticas de saúde coletiva na atenção básica.

**Descritores:** Atenção Básica à Saúde; Gestão em Saúde; Saúde Coletiva.

#### ABSTRACT

**Objective:** analyse the development of collective health actions in municipalities of the state of São Paulo, from the perspective of basic care articulators. **Method:** It is a descriptive research with qualitative approach, carried out with ten articulators of basic care. For data collection, it was used semi-structured interview technique and the speeches were submitted to content analysis, in thematic modality. **Results:** Four thematic categories emerged: conceptions about collective health; contexts that discourage the development of collective health actions; contexts that promote the development of collective health actions; and proposals for the planning and development of collective health actions. **Conclusion:** there are several challenges for the practice of collective health in basic care, among them: the lack of team meetings and the fact that some municipal health managers have difficulty for communication and dialogue with the health teams. The Community Health Agent and the basic care coordinator were identified as important allies for the promotion of collective health practices in this kind of care.

**Keywords:** Basic Health Care; Health Management; Public Health.

#### RESUMEN

**Objetivo:** analizar el desarrollo de acciones de salud colectiva en municipios del estado de São Paulo, en la perspectiva de articuladores de atención básica. **Método:** investigación de tipo descriptiva, con abordaje cualitativa, realizada con 10 Articuladores de Atención Básica. Para la colecta de los datos, fue utilizada la técnica de entrevista semiestructurada y los datos sometidos a análisis de contenido, en la modalidad temática. **Resultados:** emergieron cuatro categorías temáticas: concepciones de salud colectiva; contextos que desfavorecen el desarrollo de acciones de salud colectiva; contextos que favorecen el desarrollo de acciones de salud colectiva; e propuestas para la planeación y desarrollo de acciones de salud colectiva en la atención básica. **Conclusión:** Hay diversos desafíos apuntados para la práctica de salud colectiva en la atención básica: la falta de realización de las reuniones de equipo, gestores municipales de salud con dificultad para la comunicación y el diálogo con los equipos de salud. El agente comunitario de salud y el coordinador de atención básica fueron identificados como importantes aliados para el fomento de prácticas de salud colectiva en la atención básica.

**Descriptor:** Atención Primaria de Salud; Gestión en Salud; Salud Pública.

<sup>1</sup>Graduada em Enfermagem. Mestre em Ciências da Saúde pela Universidade Federal de São Carlos. <sup>2</sup>Graduada em Enfermagem. Doutora em Enfermagem pela Universidade Federal de São Carlos. Docente na Universidade Federal de São Carlos.

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## INTRODUCTION

Collective health arises from the critique of the hegemony of medical knowledge and the biological discourse in health care. It is defined as a field of knowledge and practices marked by interdisciplinarity and that is concerned with social needs in health (and not only with disease), understanding health as a dynamic and social process. This field, which takes collectives and social groups as their object of intervention, has sought to build knowledge and actions in the health-disease process, centered on socio-cultural and economic determinants<sup>(1)</sup>.

In this study, collective health actions are understood as those related to the apprehension and understanding of health needs promotion actions, health surveillance and education, health democratization strategies and social control, as well as inter-sectoral actions<sup>(2)</sup>.

In general, collective health faces several limitations related to the concrete means of its institutionalization in health care practices, in accordance with the constitutional principles of the Unified Health System (UHS). Because it is an area that is built from different work processes and is closely linked to the structure of society and the dynamics of social groups, collective health practices can occur in several settings<sup>(2)</sup>, among which the basic care (BC) is configured as a privileged space.

In Brazil, BC is defined as the users' preferred contact and the main gateway to the Health Care Network (HCN). This definition is confirmed by the great capillarity of BC, since it establishes itself in the places closest to the dwelling of the population, guided by the principles of universality, equity and completeness<sup>(2)</sup>.

The National Primary Care Policy (NPCP) proposes a warm and resolute BC through individual, family and collective health actions that include: health promotion and protection; prevention of injuries; diagnosis; treatment; rehabilitation; harm reduction; palliative care; and health surveillance. According to the document, such measures must be articulated to intersectoral actions that seek to impact the determinants of health and the autonomy of collectives to guarantee integral health care<sup>(3)</sup>.

However, studies show that BC workers have difficulties in assuming health as a social phenomenon, including the determinants and determinants of the health-disease process, which leads to the reproduction of the

medicalizing model of health care<sup>(4-6)</sup>. Still in these studies, the need to extend the knowledge and skills required of BC workers to work in collective health.

In this context, it is understood that collective health practices need to be built, produced and evaluated by BC teams, with the collaboration of the collective involved, as well as should be part of the training process of professionals in the area. In this way, it can contribute to a comprehensive health care in BC.

In order to qualify AB's practices in São Paulo, the State Department of Health (SDH-SP) created in 2009 an initiative called the Basic Care Articulators Program, with the objective of promoting support for the BC strengthening plan in the sphere local and regional level, develop BC evaluation and monitoring actions in conjunction with the management and technical teams and increase municipal management capacity<sup>(7)</sup>.

Along with this program, a new professional function is included within the scope of BC: the articulator. These are SDH-SP professionals, selected by technical criteria, to develop support actions in BC, focusing on municipalities with less than 100 thousand inhabitants<sup>(7)</sup>. As a work object, they assume the recognition and prioritization of local health needs and, together with health managers and teams, propose to build alternatives to address the identified problems<sup>(8)</sup>.

In this perspective, the articulators act as consultants, since they understand the context of the municipalities that support and suggest pertinent strategies for a better attention to health. They also act as communicators, since they are constantly in contact with the municipalities, integrating them and articulating them locally and regionally<sup>(7)</sup>.

The Program of Articulators of Basic Attention is little divulged in the scientific literature. Until September 2017, there were only three articles on the subject, published in the 2011<sup>(8)</sup>, 2016<sup>(9)</sup> and 2017<sup>(10)</sup>.

In the first one<sup>(8)</sup>, the authors present the implementation process of the program and affirm that it has constituted an important strategy for the strengthening of Primary Care in the state of São Paulo, both for direct support to municipal management, as well as for the teams of the Basic Health Units, in the consolidation of work processes in accordance with the NPCP guidelines. The authors conclude that, despite the positive aspects already mentioned, it is

necessary to improve the program, deepening the actions of permanent education of the articulators, so that they can offer an updated technical support and based on the theory, maintaining the dialogue and the joint construction with the counties.

The second article<sup>(9)</sup> analyzed how "visits to municipalities", one of the technical activities of the articulators, is a potentially useful resource to promote humanization in the services provided in the BC. The study concludes that the articulators can contribute to humanize the practices in the BC, be they of assistance or management, since they use a strongly based approach in the communication and the opening of spaces of conversation. However, the authors emphasize that there is no guarantee of humanizing implications in all interventions, since not all articulators adopt a practice based on dialogue; some demonstrate a more individual and technical performance. With this in view, the authors point out the need for constant analysis of the articulators' practice, about the way they position themselves and position their interlocutors when opening spaces for conversation.

The third article<sup>(10)</sup> analyzed how articulators attribute meaning to the function and describe their daily performance. It should be noted that these professionals face several challenges, situations that they are called upon to solve and, in the face of which, they often feel deprived of resources.

Based on the literature review, it is possible to verify the scarcity of studies on the Program of Articulators of Basic Care. Although the articulators' functions are not centered on collective health and the studies published about the program do not address this issue, it is relevant to recognize in the perceptions of these professionals the potential of their action, to favor the implementation of collective health practices in the BC.

Considering the importance of the role of the articulators for the construction and qualification of BC, as well as the difficulties that the implementation of collective health practices in BC still faces<sup>(2,4-6)</sup>, added to the gap in the scientific literature, this article the following questions: what conceptions do BC articulators have about collective health actions? And how do you perceive these practices in the everyday life of BC? To answer these questions, the objective was to analyze the conceptions, practices and

perspectives of BC articulators on collective health actions in municipalities of São Paulo.

## METHOD

This article presents data from an academic master's thesis titled Collective health actions from the perspective of articulators of basic health care.

It is a research with a qualitative, exploratory-descriptive approach. The choice for this approach was based on the interest to understand and analyze the social reality of the subjects with a dialectical view, which privileges contradiction and conflict; the phenomenon of transformation, the becoming, the historical movement and the totality<sup>(11)</sup>.

This research was carried out within the scope of SDH-SP, specifically in the Regional Health Care Network (RHCN 13), which is located in the northeastern macro-region of São Paulo, composed of the Regional Health Departments (RHD) of Araraquara, Barretos, Franca and Ribeirão Preto. RHCN 13 has ninety municipalities aggregated in twelve health regions, covering a total population of 3,307,320 inhabitants<sup>(12)</sup>. The program has a total of ninety professionals distributed in 64 health regions, one articulator per region; each articulator supports, on average, ten municipalities with less than 100 thousand inhabitants<sup>(7)</sup>.

The criteria for inclusion of professionals in the research were: BC articulators of RHCN 13 who were active at the time of data collection and who accepted to participate in the study. Articulators that were far from their activities were excluded. Thus, among the thirteen articulators working in the area, during the data collection, ten participated.

Data collection was done through a semi-structured interview, with a guide of guiding questions on the following topics: apprehension and understanding of health needs; health promotion, surveillance and education actions; strategies of democratization of health and social control and intersectoral actions.

The interviews were conducted in a private room at the articulators' workplace between February and March 2014. In order to guarantee the quality and reliability of the data, the interviews were recorded with the consent of the participants. To preserve anonymity, each respondent was identified with the letter A and the number corresponding to the order of his interview.

For the analysis of the results, the technique of content analysis<sup>(13)</sup> was used in the thematic modality, following the steps: impregnation of the data; determination of the registration units and their meanings; coding and classification; and treatment and interpretation of results. The first step made it possible to continue the registration units' units, ordering them by topic. Data was grouped by means of approximations and distances, and categories<sup>(13)</sup> were constructed. This analysis sought support in authors who have worked and discussed collective health in Brazil.

After approval of the research in Ethics Committee in Research with human beings of the Federal University of São Carlos (UFSCar), according to Resolution nº 466/12 of the National Health Council, under the opinion nº 509.282, we contacted the articulators to invite them, to participate voluntarily in the research; those who accepted, signed the Free and Informed Consent Term.

## RESULTS AND DISCUSSION

### Characterization of the participants' profile

Among the ten articulators interviewed, nine were female and one male. As for professional training, seven were trained in nursing, two in psychology and one in dentistry. All of them had a lato sensu postgraduate program, with specialization in public health.

With regard to working time, in the program of articulators of the BC until the moment of the interviews, seven participants were in the position since the program was implemented in the state of São Paulo, that is, five years ago; one of them had been in the program for four years; another three months ago; and one was nine months in office. Regarding the number of municipalities that each articulator supports, ranged between five and nine.

From the analysis of the interviews with the articulators, four categories emerged, which will be detailed below: conceptions of collective health; contexts that disfavor the development of collective health actions; contexts that favor the development of collective health actions; and proposals for the planning and development of collective health actions.

### Conceptions of collective health

Different conceptions of BC articulators about collective health actions were identified. These actions include those established by the priority programs institutionalized by UHS, as well as those planned based on the survey of health needs, those of intersectoriality, those that involve the promotion and prevention of health problems and those that are carried out in addition to health units. This can be seen in the following statements: "as women's health, the health of the man, the elderly, the child, the vaccination campaign, have the attendance in groups, but also that they are sometimes divided by pathologies" (A1); "Extra-mural actions in the community and with the community, occupying themselves and dealing with the dynamics and real needs of the territory" (A3); "The need to seek other sectors that go beyond health and to work always articulately in the search for integral health care" (A9); "Actions to promote health and prevent diseases" (A10).

Based on the results presented, it was possible to identify different understandings and concepts about collective health. In general, the lines converged towards the social aspect, which contemplates collective health in its theoretical construction. Such an understanding of the articulators refers to an expanded and coherent view of the precepts of collective health, understood as a field of production of knowledge and practices directed to the apprehension of health needs and its determinants, considering as its object of work the social and the development of strategies geared specifically to health promotion<sup>(14)</sup>. Thus, BC articulators can assist and promote effective and integral collective health practices, through networking, and the collective is an active part of the planning, development and evaluation of these practices.

In one of the statements, a definition of collective health actions has also emerged, which is still very much linked to the public guidelines regarding compliance with strategies proposed by specific programs, institutionalized by the State and addressed to groups of people with similar characteristics and health needs. In this way, the naturalization and standardization of actions are generated, distancing oneself from the sense proposed by collective health. This view resonates with the specific characteristics of public health, among which are the prevention of diseases and health promotion of defined

population groups, as well as the organization of individual and curative care<sup>(2)</sup>.

### **Contexts that undermine the development of collective health actions**

The articulators reported some obstacles to the development of collective health actions in BC. One difficulty pointed out is the inadequacy of the performance profile and the training of health team professionals, which still reflects the traditional model, based on clinical, individual and curative care, as we can see in the lines: "There is still a lot of this model of ready service, to meet spontaneous demand. They are only focused on the issue of individual care "(A2); "I think it's a problem of compromise, of accommodation" (A10).

It is noteworthy that the articulators point out the immediate and rationalizing profile of health workers as a factor unfavorable to the development of collective health actions.

BC is the place where health care should facilitate the link with the objective of building horizontal and lasting relationships between health teams and users. However, in Brazil, it is the logic of prompt care and hyper valuation of the response to spontaneous demand that predominates in health services<sup>(15)</sup>.

The result of this reductionist model is the great reduction in the possibilities of intervention on the part of the BC teams, given that the work process, guided by the biological and preventive paradigm, prioritizes curative services and actions, disease treatment and medicalization, emphasizing health care with intensive use of material technological apparatus<sup>(15)</sup>.

Studies show that the reductionist model of health care, pointed out by the articulators, is a difficulty perceived by other BC workers. It has been identified, for example, that the teams' performance is structured in a way that prioritizes the attendance of the complaints brought by users to services, about which, the teams intervene punctually, little solving and, in addition, making it difficult to build a link between users and health teams<sup>(5-6,16)</sup>.

It should be emphasized that this model, with prevalence of biological factors, is important to address the organic variations of the health-disease process; however, is limited in that it underestimates the importance of other factors that the human being encompasses, such as political, social and subjective<sup>(15)</sup>. In this logic, if the health teams of the BC carried out listening

and reception in a broader and more conscious way, they could identify demands that go beyond the biological aspect and, for the due confrontation of these cases, they would perceive the necessity of mobilization and differentiated organization of resources and answers, in a process where the user would be an active part<sup>(5)</sup>.

The lack of team meetings was also pointed out as a difficulty for the development of collective health actions: "Team meetings, even if a team meeting is planned per week, this space is often not guaranteed" (A2); "Where they have weekly meetings they use this data; Where they do not have it, they realize they're half disconnected" (A4).

These meetings are recognized by the articulators as moments that must be guaranteed in the BC, as they are important for the planning of health actions, according to the real needs of the territory. However, they point out that they do not happen in the practice of some teams.

In order for collective health to take place in the day-to-day work of BC, it is necessary to guarantee institutional spaces where the sharing of knowledge, discussions, evaluations and planning of practices is privileged<sup>(15)</sup>. Team meetings represent a key space for this purpose and contribute to overcoming the reproduction of only technical and routine health actions.

The lack of meetings with the teams, focusing only on the attendance of the complaint, can be attributed to the lack of motivation in the work environment due to the accumulation of functions of the BC workers and the pressure to meet the complex health needs of the population<sup>(17)</sup>.

This context undermines resolute and effective attention to the health of the population, since communication and the constant exchange of information should be part of the day-to-day work of the health teams in BC, practices that occur through the meetings. Thus, it is important to emphasize the importance of team meetings in BC as a space for dialogue, expression of opinions, construction of collective service strategies and subsidies to design better decisions<sup>(7)</sup>.

In addition to the above, another difficulty referred to refers to the way the municipal health manager acts, as can be seen from the lines: "You had time to work with the manager. And what did we notice? That this started not to reach the teams. So what we thought was happening was not "(A4); "The manager sometimes also

influences this process, making it difficult. A manager arrived, broke everything; then another manager came, he came back with everything "(A7); "He (the manager) would send it there and the strategy would work as he said it was, without scheduling, spontaneous demand only" (A8).

Some interviewees reported how difficult it has been to communicate and articulate the work between managers and health teams. There are still municipalities whose health managers do not dialogue with the teams, giving up an indispensable tool to plan and develop collective health actions. As a consequence of this, the overlap of the manager to the teams occurs and the imposition of demands in the work processes that, in the view of the articulators, are disconnected from the one advocated by BC.

Referring to the statement that the manager imposes on the teams the exclusive service to spontaneous demand, some studies have corroborated the existence of managers with a centralizing profile and with great difficulty to confer autonomy to the health teams to participate in the planning of actions. This situation generates the so-called "pain-displeasure-work" tripod, which is explained by the sensation of excision of knowledge, knowledge and desires in the work process of the teams, caused by the restriction of doing obedience and accomplishing tasks<sup>(18)</sup>.

As long as the communication networks between management and teams are interrupted, the work processes in the BC will be affected, because blocking the flow of information between the stakeholders impairs the establishment of links and prevents the structuring of a solid network<sup>(19)</sup> resulting in the formation of work processes that are increasingly diverging from the principles and objectives of NPCP.

The alternation of management in the municipalities was another difficulty highlighted, mainly affecting the work of the health teams, because, on many occasions, activities that had already been discussed and planned were interrupted, which breaks the continuity of the work and forces the teams to remain in a circle, without significant advances in the development of comprehensive and collective health actions.

It is worth mentioning that it is the responsibility of the manager, as responsible for the municipal health system, on whom the good functioning of the BC depends, in large part, to

subsidize the health teams and users in the planning and adjustment of work, according to the real needs and needs and potential of the population. Therefore, the managers' performance should be based on the incorporation of UHS principles, involving all the responsible actors in a process of exchange of experiences, knowledge, information and guidelines, promoting co-management to change the health care model, so that no one make decisions by themselves<sup>(18)</sup>.

In response to the difficulties identified in the day-to-day life of BC, the articulators point out that they have adopted strategies to enhance the performance of the teams, and the re-signification of the work in BC, the most outstanding strategy, according to the following statements: "It is precisely to show the manager the which is the family health strategy, how it should work "(A5); "What I have been looking for is trying to work with the teams to practically re-introduce what is family health, raise awareness" (A10).

Such coping strategies refer to the construction of spaces for reflection, education, awareness, awareness and discussion together with health teams and managers, always trying to analyze and remember the real attributions of BC and subsidizing new forms of health care. Thus, the objective by which the program of articulators of the BC was created, which refers to the qualification of BC in the supported municipalities<sup>(10)</sup>.

### **Contexts that favor the development of collective health actions**

This category emerged from the identification, by the articulators, of several elements that, in the day-to-day life of BC, provide, in some way, collective health actions. The articulators highlighted the role played by a member of the health team, favoring and enhancing the practice of collective health in BC, as the following speeches show: "This figure of the community agent, who goes to the community, who goes after the demands, different from the traditional basic care unit, which the user is expected to come when he has a problem "(A7); "The AQPC has come a lot on top of that for the organization. It has helped a lot because he charges you with the real assignments of BC, the questionnaire itself, it is already a way to improve the look. So when people respond to this, they begin to have

another view of the work process "(A10); "For those who work in a small municipality it is easier to reach because it has a basic care coordinator, that the priority is to evaluate the need, then the situation improves, there the planning flows, that coordinator is a facilitator exactly" (A10).

With regard to the facilitating contexts of collective health actions, it can be seen from the testimonies that, in perceiving changes in the health care model, some articulators see in the Community Health Agent (CHA) a key member of the team for achieving greater advances in the production of collective health actions in BC.

The importance of the CHA, according to the statements of the interviewees, is in its function to raise the health needs in the territory. This function gives the CHA a differentiated role in relation to the other members of the team, because it allows it to approach much more of the population, allowing the creation of bonds. However, studies show that, despite the fundamental position of the CHAs in BC, they often find themselves in situations where they do not yet have the proper preparation or instruments to respond to the wide variety of demands that emerge from the territory where they are immersed<sup>(20)</sup>.

Thus, at the same time as the CHA represent team workers, protagonists in the development of collective health actions, the lack of preparation expressed by them to meet some demands may also make them professionals who interfere negatively in these actions, when they do not have instruments, education and training adequate to carry out their work.

The implementation of the National Program for the Improvement of Access and Quality of Primary Care (AQPC) was pointed out as a favorable tool for collective health practices, since teams and municipalities receive a financial incentive to develop and evaluate actions of this nature in the health network.

Even with the notion of "how much I'm going to get the most" of capitalist logic, it seems that the AQPC institution is fostering the desire and intention for managers and teams to come closer and closer to having a better view of collective. With this, it is possible to reduce the distance between collective health and the actions carried out, through a set of practices that promote change and care management, producing the improvement and quality of BC<sup>(21)</sup>.

Another context, pointed out by articulators as a facilitator of the practice of collective health, is the figure of BC municipal coordinator, as he assists municipalities in the processes of surveying health needs, planning, execution and evaluation of actions. The BC coordinator is also responsible for: coordinating the work of the teams; articulate intra and intersectoral processes; communication and articulation between management, teams and articulator of BC. In this way, their work aims to reorganize and qualify BC practices, besides contributing to the autonomy and quality of life of the collective<sup>(22)</sup>.

### **Proposals for the planning and development of collective health actions**

The articulators made some proposals that would allow the development of collective health actions in BC. These proposals are presented as challenges to be faced in the construction of new practices by teams, managers and other actors involved in health practices: "If you work on this conception of discussing a case, it has the issue of permanent education. I think they are processes that we need to strengthen more and more" (A3); "I think raising managers' awareness is important in this regard. As I told you, you cannot have a team if the manager does not wear the shirt" (A5).

As a proposal to raise and make feasible collective health actions in the BC, articulators indicated the creation and maintenance of spaces for discussion and meeting among all involved in the production of municipal health, given that such spaces allow to overcome routine, technical and not reflective work processes by expanding the understanding of the health-disease process within the socio-environmental context through discussion and exchange of experiences, which may contribute to the qualification of the health services in the BC and to improve the quality of life of the collective.

Another proposal of the articulators is to work especially with the municipal health managers, in order to sensitize them and raise awareness for a more dialogic management with the teams of BC and with the own population of the territory. It is a perspective that privileges the expanded conception of health and its interfaces with technical, political and social aspects; a management whose objective includes improving the quality of life of people and allowing the exercise of freedom, empowerment and autonomy of collectives. In this way, it would

contribute to more and better collective health practices in BC, instead of just avoiding illness and prolonging life<sup>(3)</sup>.

In order to be able to have municipal health managers sensitive to work in the BC, with a focus on collective health, it is necessary for the managers themselves to broaden the concept of management, going beyond the responsibility of directing and organizing the municipal health system and the work of the teams. Management also includes dealing with the interests, desires, needs, knowledge and powers of the individuals involved in this process<sup>(22)</sup>.

### FINAL CONSIDERATIONS

Based on the analysis, it is possible to conclude that, in general, the concept of collective health, presented by the articulators, is related to the actions that aim to intervene in people's lives and in the social determinants of health. However, in practice, some challenges remain, such as the lack of team meetings and the difficulties of communication and dialogue between managers and health teams.

Faced with the challenges in the daily work, the articulators create coping strategies that contribute to promote and consolidate collective health actions in BC. To do this, they develop approaches based on dialogue, creating spaces for discussion and permanent education, aiming to sensitize teams and managers to work more focused on planning actions that meet the needs of the collective. It should be emphasized that such strategies are only an important beginning for the strengthening of work processes that approximate the one advocated by collective health.

The community health agent and the coordinator of the BC were identified by the articulators as important allies for the promotion of collective health practices in BC, and it is indispensable to stimulate and strengthen their participation. It is worth mentioning that, although the nurse is a key worker in the composition of the teams in terms of management, care delivery and evaluation of health actions, this professional did not appear in the articulators' speeches, either as a facilitator or as a facilitator of actions discussed here. Therefore, it is questioned: what is the role of nurses in BC to develop collective health practices? Do nurses not feel instrumental in working with focus on the precepts of collective health?

The creation of spaces to gather teams, promoting discussion and reflection, was pointed out by articulators as a strategy that deserves to be consolidated, given that it can make feasible and potentiate the practice of collective health in BC.

The perspectives of BC articulators, discussed in this article, suggest reflections on the role and responsibilities of these professionals in the necessary reorientation of the work in the BC focused on collective health. They can also instigate useful questions to construct new practices and discourses regarding the ways of achieving collective health in the context of the BC and, consequently, contribute to national and international debates regarding the qualification and enhancement of BC.

It is concluded that the articulators, acting in support, communication and education, have the potential to contribute to the achievement of collective health in BC, insofar as they propose to broaden the practices focusing on social and collective demands, besides intervention in the disease.

To that end, it is necessary that the articulators' performance is constantly analyzed and updated, since what allows or prevents the transformation of work in BC is the way the articulator acts, an aspect that this analysis does not reach. Thus, the need for further studies is highlighted in order to unveil the important role of articulators in the municipalities for the consolidation of actions based on the precepts of collective health in BC.

Another limit of this research is the fact that collective health actions are explored only from the perspective of the articulators of BC. Therefore, it is expected that future studies will approach the perspective of other subjects involved in this context, such as health teams, managers and users. It is also expected that further studies will examine the impact of articulators' work on the organization and qualification of BC.

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**Mailing address:**

Lina Karina Bernal Ordoñez  
Rodovia Washington Luis, km 235

ZIP CODE: 13565-905 - São Carlos/SP - Brazil

**E-mail:** [linakarina55@gmail.com](mailto:linakarina55@gmail.com)