THE LOCAL HEALTH COUNCIL AND THE DISCUSSION OF MENTAL HEALTH ACTIONS IN FAMILY HEALTH STRATEGY[1]

Fernanda Barreto Mielke[2], Andiara Cossetin[3] Agnes Olschowsky[4]

[2] Ph.D. candidate in Nursing, PPGENF/UFRGS. Nurse, State Health Secretary. Rio Grande do Sul, Brazil. E-mail: fernanda-mielke@saude.rs.gov.br

[3] M.Sc. student in Nursing, PPGENF/UFRGS. Nurse, Grupo Hospitalar Conceição. Rio Grande do Sul, Brazil. E-mail: andiaracossetin@gmail.com

[4] Ph.D. in Nursing. Faculty, School of Nursing of UFRGS and PPGENF/UFRGS. Rio Grande do Sul, Brazil. E-mail: agnes@enf.ufrgs.br

ABSTRACT: The aim of this paper is to evaluate the participation of Local Health Council in the discussion about the inclusion of mental health actions in the Family Health Strategy at a Family Health Unit in Porto Alegre-RS. A qualitative assessment study was developed, based on the theoretical-methodological principles of Fourth Generation Evaluation. To collect data, observation and individual interviews with 14 workers from the health center studied were used. The data were analyzed using the Constant Comparative Method. The local health council was evaluated as a facilitator in the inclusion process of mental health actions in primary health care. Thus, according to the educative nature of the evaluation process, the data were presented to members of the local council, as this deliberative entity can permit a broader discussion on the inclusion of mental health in primary care.

DESCRIPTORS: Social control, formal. Health evaluation. Mental health. Family health.

O CONSELHO LOCAL DE SAÚDE E A DISCUSSÃO DAS AÇÕES DE SAÚDE MENTAL NA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO: O artigo tem o objetivo de avaliar a participação do Conselho Local de Saúde na discussão sobre a inclusão das ações de saúde mental na Estratégia Saúde da Família em uma Unidade de Saúde da Família de Porto Alegre-RS. Estudo avaliativo qualitativo, desenvolvido a partir dos pressupostos teórico-metodológicos da Avaliação de Quarta Geração. Para a coleta de dados utilizamos observação e entrevistas individuais com 14 trabalhadores do referido serviço de saúde. Os dados foram analisados por meio do Método Comparativo Constante. O Conselho Local de Saúde foi avaliado pelos trabalhadores como um facilitador no processo de inclusão das ações de saúde mental na atenção básica. Frente a isso e, de acordo com o caráter formativo do processo avaliativo, os dados da pesquisa foram apresentados aos membros do conselho local, uma vez que essa instância deliberativa pode possibilitar a ampliação da discussão sobre a inclusão da saúde mental na atenção básica.

DESCRITORES: Controles formais da sociedade. Avaliação em saúde. Saúde mental. Saúde da família.

EL CONSEJO LOCAL DE SALUD Y LA DISCUSIÓN DE ACCIONES DE SALUD MENTAL EN LA ESTRATEGIA DE SALUD DE LA FAMILIA

RESUMEN: El artículo tiene el objetivo de evaluar la participación del Consejo Local de Salud en la discusión sobre la inclusión de acciones de salud mental en la Estrategia Salud de la Familia junto a los integrantes del Consejo Local de Salud de una unidad de salud familiar de Porto Alegre-RS. Estudio de evaluación cualitativo, desarrollado con la metodología de Evaluación de Cuarta Generación. Para la recolección de datos se utilizó la observación y entrevistas individuales con 14 trabajadores del servicio de salud estudiado. Los datos fueran analizados por medio del Método Comparativo Constante. El consejo local de salud fue evaluado como un facilitador en el proceso de inclusión de acciones de salud mental en atención primaria de salud. Así, y de acuerdo con el carácter formativo del proceso de evaluación, las informaciones fueron presentadas al consejo local, ya que esa instancia deliberativa puede posibilitar la ampliación de la discusión sobre la inclusión de la salud mental en la atención primaria.

DESCRIPTORES: Controles formales de la sociedad. Evaluación en salud. Salud mental. Salud de la familia.

INTRODUCTION

In Brazil, the 1970's and 1980's were marked by the explosion of social movements that demanded changes in the way the State operated, advancing from bureaucratic logic to society's active participation in the construction of a new State, which culminated in the social and historical process of redemocratization. It is in this process that the health reform movement gains strength when it expands its goals in society, including the struggle for the universalization of the right to health, unification of individual and group care in the same system and holistic health care, guaranteeing access and health equity for the entire population.[1]

These goals were achieved when the Brazilian Federal Constitution was issued in 1988, which established the creation of the Unified Health System (SUS). In this constitutional context, health is guaranteed as a right of all citizens and a duty of the State, highlighting three main guidelines for the functioning of the health system: decentralization, holistic care and popular participation.[2]

It is in this context that primary care stands out as an important structural axis of health care, further enhanced in 1994 through the creation of the Family Health Program (FHP). In 2006, the National Primary Health Care Policy was approved, which revised the standards and guidelines of the FHP and established the Family Health Strategy (FHS).[3] The FHS was created to reorganize care practice, centering health care on the family group as a care object ESF, and giving preference to practices that go beyond those based on cure and hospitalization.[4-5] When multiprofessional teams were put in practice, the FHS prioritized the establishment of bonding with the population, through registration within a territory, with a view to professionals' commitment and co-responsibility towards the community.[5]

As a part of the health transformation process, the Brazilian psychiatric reform historically proposes the change from asylum practices to psychosocial care in mental health, through services replacing psychiatric hospitals, based on the deinstitutionalization principle and on psychosocial rehabilitation.[6]

The Brazilian psychiatric reform constitutes a complex social process that rests on the ethical principles of inclusion, solidarity and citizenship. This process involves sociocultural, care, legal and political issues. It represents the struggle of health workers, mental health service users and family members, teaching institutions and society to achieve a radical transformation in the concept of madness, constructing the social place of psychic suffering, which is part of an individual's life.

Considering the existence of a subjective suffering component associated with health problems, one may say that a health problem is also a mental health problem.[7] In this new focus on health care, possible approaches between collective health and mental health are perceived, such as the valuation of the territory as a care space, the family group as the focus of health actions, the prioritization of welcoming and bonding with a view to the effectiveness of health care, among other aspects. In that sense, the inclusion of mental health actions in primary care, particularly through the FHS, turned into a theme for discussion and reflection on mental health policies in Brazil, as well as for health research.

In view of the complexity of this theme, in 2001, the Workshop to Discuss the National Plan for the Inclusion of Mental Health Actions in Primary Health Care took place. On this occasion, discussions focused on the mental health actions that should be developed in primary care, among which we highlight the mobilization of community resources for the sake of this paper, linking up with self-help groups, neighborhood associations, guardianship council, among others; the promotion of lectures, debates, artistic activities and groups in general, addressing specific themes according to the reality of each community; and the search for new psychosocial rehabilitation spaces in the community, such as community workshops.[7-8]

Community resources are fundamental to achieve effective results in the psychosocial rehabilitation process of users in mental suffering. When users find services and activities in the community that can welcome and include theme, they gain recognition in their community and recognize themselves as a part of it, acting as a citizen with rights and duties in the struggle for high-quality health actions, which comprise mental health.

We believe that, to use community resources, popular participation in decision-making spaces on social policies is fundamental. Not only was this right guaranteed in the 1988 Constitution[2], but it is also characterized as an action area that strengthens actual devices to respond to needs within the territory and enhances the exercise of citizenship.

In that sense, health workers should be attentive so as to mediate the population's participation in the creation of strategies to include mental health actions in primary care. It is important for users to engage in the formulation, execution, surveillance and evaluation of health practices.

We highlight the fundamental role of social control through health councils, whose composition shows a balance among 50% of representatives from the user segment, 25% for the health professional segment and 25% for managers and service providers. As a permanent and deliberate entity of the SUS, the health council is active in the formulation of strategies and in the control of the corresponding level's (federal, state, municipal) execution of the health policy, including economic and financial aspects.[9]

The aim of this paper is to assess the Local Health Council's (LHC) participation in discussions about the inclusion of mental health actions in the Family Health Strategy (FHS), based on the results of an evaluation study that involved workers from a family health unit in Porto Alegre-RS.[10]

METHOD

Qualitative assessment study, based on the methodological premises of Fourth-Generation Evaluation, characterized as a responsive constructivist evaluation, in which the stakeholders' demands are the core point of the evaluation, jointly constructed in a hermeneutic-dialectical process. Stakeholders refer to potential victims or beneficiaries of the evaluation, i.e. people with common characteristics[11] who serve as the study subjects.

Thus, the stakeholders in this study were 14 professionals from two family health teams at a health unit located in the East of Porto Alegre-RS. Each team consisted of one physician, one nurse, two nursing technicians and three community health agents. At the time of data collection, the posts of two community health agents were vacant at the unit.

The techniques used for data collection were observation and interview. Observation was used to get to know the unit's dynamics, its care flow and the relation between the family health unit and the community. This technique totaled 226 hours of observation, identified in this paper through the letter O, followed by its number. The observation script contained the description of the place, subjects, activities performed, special events, dialogues and the researcher's impressions. Individual interviews with the professionals at the FHS studied were recorded and fully transcribed, identified by the letter P, followed by the number. During the interview, the professionals were asked to comment on the following question: Talk about the difficulties and facilities to deliver mental health care at this family health unit. Data were collected between April and June 2008.

The Constant Comparative Method[12] was used for data analysis, which permits concomitant data collection and analysis. In this analysis method, the researcher's subjectivity is considered a fundamental part of the research act. During the research, the observations, interviews (as they were held) and the researcher's impressions were analyzed jointly, permitting dialectical interaction among the researcher, subjects and study object. This analysis method was chosen because it enhances these dynamics, as Fourth Generation Evaluation establishes the joint (subjects and researcher) construction of the final research result. The Constant Comparative Method involves two phases: the identification of information units and categorization. At the end of the analysis, among the categories that emerged, "Facilities to develop mental health actions" is highlighted, in which, among other themes, the LHC is discussed.

The practical application of this method involved seven steps for its development[13]: 1) contact with the field; 2) organization of the assessment, in which the researcher's main task is to conquer the right to enter the field and freely observe to get to know the context; 3) identification of interest groups; 4) development of joint constructions, in which the interviews are held based on the hermeneutic-dialectical cycle; 5) expansion of joint constructions, in which materials can be introduced in the circle to further sophisticate it; 6) preparation of the agenda for negotiation, agreeing on adequate conditions for the negotiation with the stakeholders; and 7) execution of the negotiation, during which the stakeholders' joint constructions are discussed, clarified and debated on. The negotiation allows the stakeholders to revise their constructions and make them more sophisticated.

In some interviews, the theme LHC came up as a facility for mental health care, and in others as a difficulty. During the negotiation meeting, when the findings of the stakeholders' constructions were discussed, the professionals reached the consensus that the local council is a facility,

considered a means to broaden discussions on the inclusion of mental health actions in the FHS. Notes from the negotiation meeting are identified with the letter N.

Ethical aspects were complied with, in accordance with National Health Council Resolution No. 196/1996, Ministry of Health.[14] Approval for the project was obtained from the Research Ethics Committee of the Municipal Health Secretary in Porto Alegre-RS, under number 238/2008. All participants signed the Informed Consent Term.

RESULTS AND DISCUSSION

The FHS under analysis is located in the East of Porto Alegre-RS and is part of the District Management Partenon/Lomba do Pinheiro, together with six other family health units and five primary health care units. It comprised two family health teams with 14 professionals at the time of data collection: two physicians, two nurses, four nursing technicians and six Community Health Agents (CHAs). The two teams attended approximately 1,719 families, divided in eight micro-areas. Every week, the workers held a team meeting, when administrative issues were discussed, as well as the organization of the work process and issues the service had to solve during the week.

The work hours of the service studied are from 8h till 12h and from 13h till 17h. Its activities started in 2002, when the LHC was also created on a temporary base, to be followed by an election, which had not been held until the time of data collection. The fact that this election had not taken place yet may be related to a range of factors, as the election is a complex process that involves the correlation of political, party, opposition, administrative and stakeholder forces, which sometimes make its installation impossible or difficult.

During data collection, the LHC was organizing a seminar on social control, aimed at discussing the importance of popular participation with the community, as well as the need to hold the election of the Local Health Council.

Council meetings took place monthly, on the last Monday, in a room at the health unit. One of the nurses at the unit was in charge of coordination and three user councilors participated, who lived in the two coverage areas of the family health unit. The user councilors were also involved in other forms of institutionalized popular participation, such as the participatory budget and the district health council meeting.

All local council meetings were registered in the service's book of proceedings. The agendas concentrated on issues related to the organization and functioning of the FHS studies, as appointed in the following observation: [...] *the agendas were: the week of LIRA* [Survey of Rapid *Aedes aegypti* Index], *during which it was explained that the CHAs are on the streets, but cannot attend to demands; micro-areas without CHA, so that the councilors could explain to the community that there is a turnover among the CHAs so as to minimally cover these areas* [...] *territorialization, it was mentioned that a district management meeting would take place next Wednesday to discuss the two units' territorialization* [study unit and another one], *as one of the micro-areas would possibly be transferred to the other unit* (O15).

We consider that discussing issues related to the functioning of the family health unit is important, considering the population's involvement and participation in the construction of the health service with a view to responding to the community's actual health needs. We do find it important, however, to highlight that the role of health councilors is not only to explain the lack of (human, financial, material) resources to the community, as this is a function of the executive sector – health workers and managers. Councilors should work to supervise and monitor the development of health actions and services, forwarding any signs of accusations to competent entities.[15] Hence, the task of the LHC members at the FHS studied should be that of demanding the Municipal Health Secretary to hire two CHAs.

Therefore, we believe that further clarifications are due about the political-participatory nature of the LHC, as its function is to define what constitutes public interest, to represent the will of the group and appoint priorities for governmental action.[16]

The councilors' activities need to be broadened to issues related to the macro-political of the health system, as the articulation with other sectors in society, like education, housing, leisure, will strengthen health production, as an expanded action that takes into account contexts and singularities in different situations. Thus, investments are needed in the councilors' political preparation, with SUS principles and guidelines serving as the structural axis, so that the preparation is not political-partisan, but oriented at health policies.

We evaluate that both the community and professionals at the unit under analysis hardly participate in LHC meetings. This evaluation

was based on the observations and interviews, as described here: *at 9h30min there was a local health council meeting, to which the nurse invited the members but, according to her, 'the usual ones attended'* (O15); [...] *as for our council here, it has become emptier and emptier* [...] *it is not a strong council* [...] *it is weakened, it is not strong* (E8).

The emptying of the LHC may be related to aspects like the local participation culture; political interferences, especially of neoliberal origins; the logic of immediate problem solving; the population's disbelief in the health system due to its bureaucratization; and the population's formation to clearly understand its role in social control.

Another factor is highlighted, which we believe interferes directly in the emptying of this social control entity. The community only appoints aspects that are not satisfactory and, thus, the LHC turns into a space of "collective complaint". In view of the functions indicated for the LHC, we consider that this 'claiming' limit should be overcome, as the proposal is for a "control that is not only supervisory, but also deliberative and pluralistic, whose functions go far beyond that of a mere forum for claims or a qualified channel to process demands".[16:414] Claims for improvements in health care and health service access are mobilizing instruments to seek spaces like local health councils, which should be used as an incentive to put in practice the community's participation in deliberative entities that permit articulations in search of health care benefits and autonomy for the participating subjects.

The population needs to understand social control as a conquest, in which citizens, organized through reflection, debate on and go for their right to health, furthering the understanding that health councils are spaces for participation that can guarantee the construction and optimization of health services. Raising the population's awareness is the daily challenge health services and professionals face, in a perspective that ranges from the pedagogical dimension to the construction of citizenship. Professionals play a fundamental role in stimulating popular participation in health services, as a way of strengthening the SUS, expanding access to the theoretical-political contents of legislation and social movements, giving voice to the community's demands and proposing co-accountability in the search for results.[17]

Despite the difficulties faced, during the negotiation meeting, the professionals assessed the LHC as a possibility to broaden discussions about the inclusion of mental health in primary health care. The professionals understand that support from the LHC in this respect is important and is considered a facilitator the family health unit has at its disposal.

[...] *I think it would have to start somewhere; of course that place is the council, it would be good to take it to the local council and start to go up, upwards until you reach something; taking it to the local council would be a start* (P4).

[...] *nurse says that the local council represents a facility and everyone agrees. The physician comments that it is important because of the social control issue, and can represent a door to put in practice health actions* (N).

Social control serves as an important tool to improve the population's health situation[17], as it constitutes a political space that, due to the proximity with and experience of reality in the coverage area, deals with the community's needs, interests, difficulties and anxieties. Thus, it can drive changes directly related with health promotion, considering popular participation as fundamental in the setting of priorities, in decisions and in the elaboration of strategies to reach the best possible health level, developing policies that depart from health problems and needs.[18]

As the role of the LHC is to supervise the execution of the public health policy and that one of the axes of the municipal mental health policy is the qualification of primary health care[19], we consider the LHC as an entity with potential to broaden the discussion on the inclusion of mental health actions in the FHS.

The research results[10] were presented at the LHC meeting in August 2008, upon the request of the FHS team studied during the negotiation meeting. When this information was presented to the LHC, the results were organized according to the priorities the FHS professionals had appointed, who evaluated the need to discuss matrix support in mental health with the councilors, as well as the city's insufficient and fragmented mental health network and the mental health of workers at the FHS under analysis.

Thus, a document was organized that presented the research and its objectives, the categories obtained from data analysis, highlighting the issues the FHS teams had defined for more detailed discussion. [...] *present during the Local Health Council meeting: the unit nurse, a user invited to participate in the meeting, the three user councilors, a master's student from UFRGS and the researcher.*

[...] I gave a copy of the summary organized for this moment for all participants present. We read it and I explained each item. When we reached the part of the results, I talked about its category and its themes. As topics about the mental health network, the matrix support and workers' mental health were highlighted in the material, we concentrated on these discussions (O37).

The mental health network in the city was the first topic in the discussion of the presented data, which was assessed as insufficient, and existing services are not articulated. The city's specialized mental health network included four CAPSII, two CAPSad (one in each implantation phase), two CAPSi, one health and work production workshop, two therapeutic residences, one protected pension, one damage reduction program, one therapeutic community, one mental health emergency unit, outpatient clinics and seven mental health teams. The network also offered psychiatric beds in two of the city's general hospitals, as well as affiliated services for hospitalization: two psychiatric hospitals, one psychiatric clinic and three general hospitals with psychiatric beds.[19]

The research participants reported difficulties to be attended at the services and to get access to mental health care, independently of the type of service wanted and/or needed, giving examples of neighbors and even relatives who faced this situation.

In the discussion about matrix support, inquiries emerged about the logic matrix-based organization of mental health care. It was explained that this work method proposes the existence of a specialized mental health team, which could be the mental health teams existing in the city or through the implantation of the NASF – Family Health Support Group. These specialized teams would deliver care together with the family health team, which is considered the reference team. Besides offering this care support, matrix support also offers technical-pedagogical support, permitting permanent in-service education and approaching FHS professionals to mental health debates and discussions. The goal is for reference teams to be more autonomous to respond to mild cases like anxiety and mild depression.[20]

Based on this discussion, we evaluate that the implementation of matrix support as a strategy to strengthen the Psychiatric Reform, involves the approval of a mental health policy in the city, included the municipal government's decision and support. Through social control, as a space of power, users and health workers can tension and address this agenda as a priority for implementation in the city's mental health administration.

Another point that was addressed with the councilors was the mental health of professionals at the FHS studies, who assess that their care needs as workers are not taken into account. We debated that FHS work requires that professionals constantly offer themselves to welcome health demands, which can cause moments of tension and stress in the accomplishment of work.

Work can dis-enhance human life when it is related to work burden and stress.[21] Suffering at work occurs when workers cannot find spaces of listening to relieve their doubts and anxieties, as well as to discuss and reorganize their work processes, thus enhancing the emergence of suffering and threats on workers' mental health.

The councilors demonstrated concern with and interest in this agenda as, if the professionals experience their work without pleasure, they can do their activities routinely, without commitment to health production, as people can only deliver care if they receive care. In addition, there are the precarious work conditions and outsourcing of human resources, practices that cooperate to discourage workers to do their work with motivation, valuation and professional accomplishment.

This discussion with the LHC about mental health demands permitted the presentation of a reality so far unknown to the user councilors, indicating the macro-political aspects of the health system in which, through social control, they can effectively participate in the management and implementation of psychosocial care.

In our opinion, the presentation of these data to the councilors led to their disaccommodation, mobilizing them in the search for political-participatory activities as LHC members. This assertion is based on the fact that the councilors requested authorization to take the contents of discussions to the agenda of the district health council meeting. We consider that presenting the results to the health councilors contributes to their understanding about the organization of the LHC under analysis and about the demands needed for health care, considering that this care takes form in the co-accountability agreed upon between professionals and the community.

Finally, we consider that social control, through the LHC, associated with professionals and the community, enhances the discussion about

the inclusion of mental health actions in the territorial space. Social control appears as an important device to interfere in and transform policies, professional and social culture, claiming the right to health, better work conditions at the FHS and the construction of citizenship. This departs from the people who fight for the collective construction of health beyond services and, when these are needed, it should be high-quality public services in terms of human resources, responsibility, solidarity and political-social commitment to society.

FINAL CONSIDERATIONS

The participatory evaluation developed with the professionals at an FHS in Porto Alegre-RS appointed the LHC as an important tool to broaden discussion about the inclusion of mental health actions in primary health care, strengthening the tensioning of this specific issue and envisaging new forms of mental health care.

The study also indicated some difficulties that need to be overcome, such as the expansion of councilors' actions in the macro-political spaces of the health system. This demands investments in the councilors' preparation. This preparation should be based on SUS principles and guideline, centering on the perspective of health as a right of all citizens. A serious preparation will result in more critical, reflexive and creative councilors.

We underline the LHC's potential as a space of social control to strengthen the principles and guidelines of the SUS, and also of the Psychiatric Reform, permitting the social reinsertion of mental health users in the city's space, with a view to health promotion.

Despite the appointed difficulties, valuing the LHC as a facility to develop mental health actions within the territory demonstrates that professionals at the FHS studies consider this instrument as a driver of changes and transformation in the population's quality of life and health.

REFERENCES

1. Baptista TWF. O direito à saúde no Brasil: sobre como chegamos ao Sistema Único de Saúde e o que esperamos dele. In: Escola Politécnica de Saúde Joaquim Venâncio, organizador. Textos de apoio em políticas de saúde. Rio de Janeiro (RJ): Fiocruz, 2005. p.11-41.

2. Brasil. Constituição da República Federativa do Brasil, de 5 de outubro de 1988. Brasília(DF): Senado Brasileiro, 1988.

3. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília (DF): MS; 2006.

4. Franco T, Merhy EE. PSF: contradições e novos desafios. Conferência Nacional de Saúde on-line. Brasília (DF): MS; 1999 [acesso 2008 Jul 05]. Disponível em: http://www.datasus.gov.br/cns/temas/tribuna/psftito.htm

5. Ministério da Saúde (BR). Atenção básica e a saúde da família [online]. Brasília (DF): Ministério da Saúde, 2004. [acesso 2006 Out 15]. Disponível em: http://dtr2004.saude.gov.br/dab/atencaobasica.php

6. Amarante P. Asilos, alienados e alienistas. In: Amarante P, organizador. Psiquiatria social e reforma psiquiátrica. Rio de Janeiro (RJ): Fiocruz, 2008. p.73-84.

7. Ministério da Saúde (BR). Saúde mental e atenção básica: o vínculo e o diálogo necessários. Brasília (DF): Ministério da Saúde, 2003.

8. Ministério da Saúde (BR). Relatório da oficina de trabalho para discussão do Plano Nacional de Inclusão das Ações de Saúde Mental na Atenção Básica. Brasília (DF): Ministério da Saúde, 2001.

9. Ministério da Saúde (BR). Lei nº 8142, de 28 de dezembro 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. Diário Oficial da República Federativa do Brasil, 31 Dez 1990.

10. Mielke FB. Ações de saúde mental na estratégia saúde da família: um estudo avaliativo. [dissertação]. Porto Alegre (RS): Universidade Federal do Rio Grande do Sul, Programa de Pós-Graduação em Enfermagem; 2009.

11. Guba E, Lincoln Y. Fourth generation evaluation. Newbury Park (CA): Sage Publications; 1989.

12. Lincoln Y, Guba E. Naturalistic inquiry. Newbury Park (CA): Sage Publications; 1985.

13. Wetzel C. Avaliação de serviço em saúde mental: a construção de um processo participativo [tese]. Ribeirão Preto (SP): Universidade de São Paulo, Escola de Enfermagem; 2005.

14. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº196, de 10 de outubro de 1996. Brasília: Ministério da Saúde, 1996.

15. Ministério da Saúde (BR). Decreto nº 333, de 04 de novembro de 2003. Aprova as diretrizes para criação, reformulação, estruturação e funcionamento dos Conselhos de Saúde. Diário Oficial da República Federativa do Brasil, 04 Dez 2003. Seção 1.

16. Aciole GG. Das dimensões pedagógicas para a construção da cidadania no exercício do controle social. Interface - Comunic Saúde Educ. 2007 Set-Dez; 11(23):409-26.

17. Nogueira FCP, Lima LHO, Wolfovitch RGS, Nascimento SM, Lopes SRM. Implantação de um conselho local de saúde: desafios da prática do controle social. Rev Baiana Saúde Pública. 2008 Jan-Abr; 32(1):104-10.

18. Sícoli JL, Nascimento PR. Promoção da saúde: concepções, princípios e operacionalização. Interface - Comunic Saúde Educ. 2003 Fev; 7(12):91-112.

19. Prefeitura Municipal de Porto Alegre. Política de saúde mental do município de Porto Alegre [online], 2008 [acesso 2008 Jul 21]. Disponível em: http://www2.portoalegre.rs.gov.br/sms/default.php?p_secao=686

20. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Diretrizes do NASF: Núcleo de Apoio à Saúde da Família. Brasília (DF): MS; 2010.

21. Azambuja EP, Fernandes GFM, Kerber NPC, Silveira RS, Silva AL, Gonçalves LHT, et al. Significados do trabalho no processo de viver de trabalhadoras de um programa de saúde da família. Texto Contexto Enferm. 2007 Jan-Mar; 16(1):71-9.

Correspondence to: Fernanda Barreto Mielke
Rua Cel. Fernando Machado, 851 ap. 504
90010-321 – Centro, Porto Alegre, RS, Brasil
E-mail: fernanda-mielke@saude.rs.gov.br