

## Social participation in Primary Health Care towards the 2030 Agenda

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**Abstract** *Listening to society is an ethical reference to respond to its legitimate needs and aspirations. Considering as presuppositions the social participation and the right to the city, which are part of the 2030 Agenda, this study sought to recognize the voice of users that evaluated PHC services and their attributes. This descriptive and cross-sectional study used national ministerial evaluation data, outlining a region with 323 teams in 80 municipalities in the state of São Paulo and 1,272 users heard by authors. Users were mostly female, over 51 years old, with low income and schooling, eliciting challenges to population aging and selective care. Around 93% were 20 minutes away from health services and opening on Saturdays (43%) and at night (38%) would facilitate access. Some 60% were received without scheduling and 62% did not consider services prepared for urgent care. Some 85% received Community Health Workers and 40% other professionals, suggesting disparities in the incorporation of the territory to the care production process. In line with National Primary Health Care Policy and what is recommended by international conferences, social participation was recognized as a way to address the multiple aspects in the construction of universal health.*

**Key words** *Primary Health Care, Social participation, Health evaluation*

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## Introduction

*People who are vulnerable should be empowered.*  
(2030 Agenda)

Based on the experience of the United Nations Millennium Development Goals (MDG) agenda, which was in force between 2000 and 2015, and in compliance of which Brazil<sup>1</sup> was highlighted, the 2030 Agenda was set up focusing on the social, economic and environmental areas. Covering the period 2016-2030, it contains the 17 Sustainable Development Goals (SDG) and their 169 targets<sup>2</sup>.

Complying with the Agenda requires that countries address their different realities, capacities and levels of development, facing specific challenges for its establishment and implementation. Each government is primarily responsible for monitoring and evaluating progress achieved at the regional, national and global levels and should develop and use indicators consisting of quality, accessible, up-to-date and reliable disaggregated data, the use of which should be the key to decision-making<sup>2</sup>.

SDGs' advancement is in line with the promotion of the right to the city, a matter initially brought about by Lefebvre, in which he states that "the right to the city is not the right to access or return to traditional cities, but it is the right to transformed and renewed urban life, which includes the "urban" as a meeting place, which prioritizes the use value, the inscription in the space of a time elevated to the position of supreme good among the goods, that finds its morphological base and its practical sensitive fulfillment"<sup>3</sup>.

Thus, it is necessary to redefine forms, functions and structures of the city, which are economic, political and cultural, since the city historically shaped is no more, although the "urban" persists. Lefebvre posits that possible theoretical objects should be constituted, the results of which must focus precisely on the reality that placed them under ceaseless feedback<sup>3</sup>.

In this perspective, regional and sub-regional frameworks facilitate effective translation of policies adopted in concrete actions to achieve SDGs<sup>2</sup> and promote the right to the city.

This article highlights SDG 3, aimed at health, and more specifically target 3.8: achieving universal health coverage, including protection of financial risk, access to essential quality health services and access to essential, safe, effective, quality and affordable medicines and vaccines for all<sup>2</sup>.

Thus, the importance of ensuring first contact care is highlighted, and this is one of the essential attributes of Primary Health Care (PHC), since it corresponds to the accessibility and use of the service by users for each new problem or new health problem incident, considering in the composition of this attribute how users perceive accessibility (for example, the geographic and time characteristics of the access) and use (easy access is associated or not with use and resolubility)<sup>4</sup>.

Also relevant is ensuring universal and continuous access to qualified and resolute services, receiving, linking and making user co-responsible in health care. PHC must organize itself to universally receive, listen and provide an active response to the population's health problems, reducing their suffering and harm, and taking responsibility for the response provided within or outside the PHC itself<sup>5</sup>.

In view of issues raised by SDG 3, the availability of the Unified Health System (SUS), which is universal and egalitarian, with services organized at levels of care, not by hierarchy of importance, but by greater or lesser technological density incorporated into each sphere has been reaffirmed in Brazil.

Despite the many challenges it has been facing since its inception, SUS has been a profound change in the health of Brazilian society as a public ethical-political project aimed at social protection.

Some of the major changes stem from the adoption of an expanded concept of health, its recognition as a social right of all citizens, the state's responsibility in this process and the strong call to the participation of society in the construction of a project that transcends the care realm, to require the conscious exercise of full citizenship - the basis of a healthy society, which gives rise to possibilities for a new social role, viscerally relevant in the SUS.

This state policy has many common aspects with SDGs 3 and 17 (regarding the recognition of social participation)<sup>2,5</sup>. It also has a direct impact on the promotion of healthy cities, aligned with the right to the city.

According to Harvey<sup>6</sup>, this right is far from the individual freedom of access to urban resources, because it is a "right to change ourselves by changing the city". It is primarily a common right, then, an individual right, since transformation to which it refers is linked to the exercise of a collective power that can freely shape the (re) construction of the city and of our self.

The rationale of citizenship and the production of life require recognition in the complex

process of comprehensive care, assuming health as a social production and PHC with its attributes of valuing the community, accessible and qualified, integrated into health care networks and with a power to coordinate longitudinal, comprehensive, universal and egalitarian care<sup>7</sup>.

According to the National Primary Health Care Policy (PNAB)<sup>5</sup>, PHC is a set of individual and collective health actions, which includes health promotion, protection and prevention, diagnosis, treatment, rehabilitation, harm reduction and maintenance of health, focusing on an integrality that influences the autonomy and health situation of the people and on the conditionants and determinants of health of the communities.

PHC must also contribute to the reorientation of the SUS care and management model, supporting and stimulating the priority adoption of the Family Health Strategy (ESF) in Brazilian municipalities, given its tactical potential for consolidation, qualification and expansion of PHC itself<sup>5,8</sup>.

The implementation of these paradigmatic changes evidenced the need to evaluate and qualify PHC services. Thus, the Program for the Improvement of Access and Quality of Primary Health Care (PMAQ-AB), hereinafter referred to as PMAQ, was established in 2011 and develops in successive of PHC evaluation cycles, favoring professionals and SUS users<sup>9</sup>.

This is a powerful and strategic moment to assess what has been built and recognize the social and political weaknesses, establishing new directions aligned with 2030 Agenda.

Following on from these arguments, the 2030 Agenda signatories have committed to adopting and following some guiding principles of the process of evaluation and monitoring of goals and targets that are: open, inclusive, participatory and transparent for all stakeholders; people-centered, gender-sensitive and focused on the poorest and most vulnerable; based on existing platforms and processes, if any, avoiding duplication; and that strengthen national data systems and evaluation programs<sup>2</sup>.

Following PHC's capillarity, PMAQ eventually produces evaluation data capable of characterizing regional territories and settings in various scales. This is also in line with the agreement underpinning the 2030 Agenda, which considers the contribution of indigenous people, civil society, private sector and others, providing opportunities for "peer learning, also through voluntary analysis, sharing best practices and discussing shared targets... Inclusive regional processes will use na-

tional level assessments and contribute to monitoring and evaluation at the global level [...] "<sup>2</sup>.

The strong specific characteristics of the PMAQ results shown below meet certain health and social participation targets brought by SDGs, with a view to the right to the city and quality health services, and the need to listen to citizens to improve the process of production of care and life in the territories.

## Objective

This work seeks to give visibility to users' voicing as to their possibilities and difficulties of access to these public PHC services.

## Material and methodology

This is a descriptive cross-sectional study using a secondary source based on the external evaluation database of PMAQ - Cycle II, which occurred in 2014. This work covered 80 municipalities that adhered to the evaluation process in a Regional Health Care Network (RRAS) of the State of São Paulo, with 90 municipalities, totaling 3,363,849 inhabitants, and authors participated in the collection in the corresponding area.

The external evaluation provides a set of variables aimed at ascertaining accessibility and quality of PHC provided by the set of PHC facilities (UBS) involved in the Program. The evaluation tools are divided into Modules and seek to cover the structural and input realms of the health facilities, the work process and, in Module III adopted in this study, interviews with users in the health units are included<sup>10,11</sup>.

The variables discussed here derive from five sub-realms: user identification, access to health services, reception of walk-in demand, comprehensive health care and linkage and care accountability<sup>11</sup>. Four users from each health team participating in the evaluation process were interviewed, totaling 1,272 people, selected according to the Ministry of Health criteria<sup>11</sup>. The answers obtained were analyzed through descriptive statistics, based on the theoretical reference of PHC and its four essential attributes: Longitudinality, Integrality, Coordination of Care and Access/Accessibility<sup>4</sup>.

The Research Ethics Committee of the Hospital das Clínicas of the Medical School of Ribeirão Preto-USP approved the master's research that originated this study.

## Results

### Characterization of respondents

The mean age of respondents was 50 years, with 50% of them being 51 years old or older, with a predominance of female users (77%) (Table 1).

Regarding income, worth highlighting is the high percentage (75%) of respondents who did not reply, either because they were unemployed or because they could not remember how much they earned in the month preceding the interview. Of these 75%, 80% were women and 20% were men. When informed, amounts ranged from one to three minimum wages for 20% of respondents, and 0.7% received four minimum wages or more (Table 1).

With respect to schooling, 40% of respondents had incomplete elementary school, about 20% had secondary school education and 5% attended partially or completed higher education and/or postgraduate studies (Table 1).

### Access and accessibility

Travel time from residence to facilities was 10 minutes for 75% of the respondents and 20 minutes for 18% of them (Table 2).

When asked about services' working hours, morning hours (100%) and afternoons (99%)

prevailed, in contrast to nighttime (3%). Around 43% of users reported access facilitation if services opened on Saturdays, 38% at night, 26% on Sundays, and 22% if they worked until 6:00 pm (Table 2).

Regarding waiting time for scheduled appointments, 69% of users' voiced delays in their service (Table 2).

### Longitudinality

When asked the following question: "How are you received by the service when you walk into the facility without an appointment?", 32% reported it has never been necessary to do so, 60% said they were "very well" or "well" served, while 5% rated attendance as "fair" and less than 3% said it was "bad / very bad" (Table 3).

Approximately 62% of users did not consider facilities as places capable of dealing with urgency in situations of need (Table 3).

### Integrity of care

Results show that 90% of users answered affirmatively about having their needs and / or problems solved in the facilities. When asked: "Other than your complaint, do health professionals ask about other issues in your life?", 34% reported that they were never or almost never asked this question (Table 4).

**Table 1.** Characterization of users interviewed in PMAQ Cycle II. RRAS 13-SP, 2014.

Age	
Mean	50 years
18-50 years	50%
≥ 51 years	50%
Gender	
Female	77%
Male	33%
Income	
Not informed	75%
1-3 minimum wages	20%
≥ 4 minimum wages	0,7%
Schooling	
Incomplete elementary school	40%
Secondary school completed	20%
Incomplete/complete higher education/postgraduate studies	5%

Source: PMAQ Cycle II database, Ministry of Health.

**Table 2.** Access and accessibility of users interviewed in PMAQ Cycle II. RRAS 13-SP, 2014.

Travel (minutes)	
≤ 10	75%
≤ 20	18%
Working hours	
Morning	100%
Afternoon	99%
Night	3%
Facilitating access	
Saturdays	43%
Nighttime	38%
Sundays	26%
Until 18h	22%
Waiting time delay	69%

Source: PMAQ Cycle II database, Ministry of Health.

### Coordination of care

The following variable was applied only to users already referred to other professionals and health services, making up 69% (n = 880) of the respondents. They were asked whether they knew about the types of referral to consultations in other services, allowing them multiple choices in response. Some 52% of respondents said the consultation was scheduled by the facility and informed later; 22% said the appointment was scheduled and informed immediately at the service and 40% were among those who reported receiving a referral or reference in order to seek other services (Table 5).

Regarding home visits, 85% of respondents reported receiving regular visits from community health workers (ACS) and 2% did not have these professionals. On receiving visits from other health professionals, 58% answered “never” or “almost never” and 40% “always” or “most of the time” (Table 5).

### Discussion

#### Characterization of respondents

Taking into account that interviews were conducted with users found in health services, we need to consider that results are relative to a population that can reach these services, with all its peculiar characteristics: predominance of women and the elderly. According to the 2010 IBGE Census<sup>12</sup>, 77% of respondents were females, which is disproportionate to the 51% of the Brazilian population. A study<sup>13</sup> involving satisfaction of PHC facilities users reiterates this female profile, identifying the prevalence of women in 84% of respondents and low schooling (53% did not complete elementary school), although the mean age was 30-39 years.

This setting reinforces the need to provide women’s health services (emphasized in SDG 5, on gender equality and female empowerment) and, more importantly, to bring health services closer to the male public. The National Comprehensive Men’s Health Care Policy<sup>14</sup>, considering this problem and diseases that result from it, points out that it is necessary to promote health actions that contribute significantly to the understanding of the singular male reality in its diverse sociocultural and political and economic contexts.

It should be noted that the tool includes gender-related variables. However, there is no

information regarding the gender of the users interviewed, a growing theme in the various social sectors, and a recent reason for new discussions and actions, especially in the area of health. It would be enriching to have this data available for the evaluation of services, to better characterize the population that seek them, raise demands and design actions and break with possible forced correlations between sex and gender.

**Table 3.** Longitudinality of users interviewed in PMAQ Cycle II. RRAS 13-SP, 2014.

Reception when visiting a UBS without an appointment	
Very good / Good	60%
Fair	5%
Bad/very bad	3%
Never needed to do this	32%
Considering UBS for urgent care	62%

Source: PMAQ Cycle II database, Ministry of Health

**Table 4.** Integrality of care for users interviewed in PMAQ Cycle II. RRAS 13-SP, 2014.

Solving needs / problems at UBS itself	
Always / Most of the time	90%
Almost never / never	9%
Investigation beyond initial complaint	
Always / Most of the time	65%
Almost never / never	34%

Source: PMAQ Cycle II database, Ministry of Health.

**Table 5.** Coordination of care for users interviewed in PMAQ Cycle II. RRAS 13-SP, 2014.

Referrals (n = 880)	
UBS schedules and informs later	52%
UBS schedules and informs immediately	22%
Receives the referral / reference “card”	40%
Home visit	
Community Health Worker	85%
Community Health Worker not available	2%
Other professionals (Always / Most of the time)	40%

Source: PMAQ Cycle II database, Ministry of Health.

This profile also refers to the challenges posed by population aging to the various social sectors in the coming years, and in particular to the health system, which should incorporate the high costs of technological adaptation in order to perform integral actions for the health of the elderly, ensuring the perspective of equity and universality, as per SDG 3.

There is also a greater need for attention to the prevention and protection of the health of lower age groups, in order to reduce future negative impacts of aging on the SUS and the entire society, when early retirements, leave due to chronic diseases and so forth are requested. Studies<sup>15-17</sup> point out the implications for the economy of the aging process and the high incidence of chronic diseases, such as diabetes, hypertension, depression and its comorbidities, with an estimated impact for 2030 of 8.7% of GDP.

On the other hand, approximately 50% of the other respondents were in the 19-50 years age group, which should warn health teams about the importance of responding to the needs of reproductive age and childcare, as well as the complex aspects related to participation in the labor market, such as occupational diseases and accidents, often unknown due to the reported difficulties of accessibility resulting from the working hours of services incompatible with working hours of these users and other potential users.

Regarding income, the very high percentage of respondents who did not reply, who did not work or remember how much they received in the month prior to the interview causes a stir. About 75% of users were unemployed / could not say how much they received the previous month, and 80% of them were women and 20% men. The possibility of there being a certain constraint on the part of respondents in providing strangers with information restricted to the private sphere stands out. Users who provided amounts were characterized as those earning 1-3 minimum wages.

A PHC user population with income conditions below levels to meet the most basic needs of daily life is thus configured and informed income is often shared by an entire family. It is, therefore, the type of population that does not have supplementary health services and relies mostly and exclusively on the SUS to ensure an essential right.

The schooling variable revealed that the profile of users found at this gateway of the SUS is of lower educational level, consistent with the above-mentioned data and analyzed vis-à-vis income and occupation.

PHC has an important aspect that considers it as poor care to poor people<sup>18</sup>, called selective PHC, which is incipient care wise and devoid of increased resources, reinforcing the idea of “SUS for the poor”; a possible response to the use of health plans as an upward mobility indicator.

Considering the interweaving of SDG 3 with other SDGs and targets, it is relevant to consider that providing selective services perpetuates the idea of poverty linked to public health services. The impact of poverty on health profile stems from the persistent situations of disadvantage and discrimination experienced by certain social groups and that affect health differently. On the other hand, diseases in certain social groups contribute to reinforce social and economic vulnerabilities, resulting in a persistent perverse cycle of poverty.

#### Access and accessibility

Users who said they spend a maximum of 20 minutes traveling the distance between their home and the UBS account for 93% of the sample. This is within the suggested patterns, which propose that travel time does not exceed 30 minutes<sup>19</sup>.

Several other factors can influence access and accessibility, besides geographical distance, such as social and community aspects, the type of community demand in relation to the technological standard of services, organizational issues in the structuring of health services (schedule, working hours, availability of professionals, etc.)<sup>4</sup>.

Considering that interviews were carried out with users who were at the health facilities, it may be that users living in remote rural areas (and the like) with poor coverage did not have the opportunity to express their perception about traveling distance to the UBS, implying a gap in users studied, some perhaps with greater vulnerability and difficulty to access services. Recognizing these issues and seeking solutions to solve them is in line with what is stated in SDG 1 target 1.3: Implement, at the national level, the appropriate social protection measures and systems [the SUS being one] for all, [...] and to achieve enough coverage of the poor and vulnerable<sup>2</sup> by 2030.

It is necessary to consider here what Harvey<sup>6</sup> referred to in relation to the right to the city, when affirming that the limits of the urban are gradually disappearing, crossing the rural and reaching global dimensions. The above result refers to what Harvey defines as “the forma-

tion of many “microstates”, cities that consist of “strengthened fragments” and closed communities, where different parts live under different urban conditions.

UBS working hours predominantly in mornings and afternoons and almost nonexistent at night hinder access of community members with working days that conflict with the health services’ working hours.

As the collection was directed to users found at facilities, that is, those who had access to the service, if this same questioning was done randomly in the community at times when workers are at home, these percentages could vary substantially. Again, the voicing of community needs is impaired.

Taking into account the assumption of PHC that is close and open to the daily reality of users and the community, as stated in PNAB<sup>5</sup>, if the access attribute is not ensured, and if there are no other forms of access to other services that meet the health needs of the population (bearing in mind, for example, that most RRAS municipalities only have PHC services locally), PHC is perpetuated as unable to resolve or even meet the health needs of citizens.

Regarding the waiting time for service in scheduled appointments, users’ voice reveals a delay in their attendance of 69%, leading to the perpetuation of a SUS that is difficult to access. A study<sup>13</sup> of users’ satisfaction identified that the most well evaluated aspect was the easy scheduling of consultations, with 22% of “very good” responses, followed by the support offered by health facility professionals, besides professionals who provided care, with 22% “very good” responses. Also in this research, the worst evaluation referred to the waiting time for consultation, with 56% of dissatisfied users.

### Longitudinality

Data revealed the welcoming PHC for most of its users, fulfilling its role as a gateway to the SUS to create strong links in the care and management of cases<sup>5</sup>. However, it should be noted again that those who do not have access to PHC services were not able to give their opinion.

As for the 62% who did not consider the facilities prepared to handle emergencies (if necessary), we understand that there is a flaw in the way the service is viewed and evaluated by users, since PHC is a preferred reference point in cases of urgency<sup>4,5,20</sup>. Strengthening PHC and making it recognized as a preferential point of care, in

urgent situations or not, is a necessary task to enable its attributes.

In a study called “Emergency care or primary care: patients’ choices in the SUS”, Caccia-Bava et al.<sup>21</sup> identified that, in relation to the attribute of longitudinality of care with establishment of positive linkages between patients and members of health teams, about 20 % of respondents report that this tie was not established with primary care, but, in part, with the Emergency Care Facility (ECF). Other findings in the study relate to the reasons given by patients with PHC-compliant complaints to seek out the emergency care service. In this case, 12.4% stated that they might need urgent care (mischaracterizing the UBS as a possibility for this service) and 9.6% because they considered a greater availability of resources in the ECF than in the UBS.

In order to ensure longitudinality with PHC as a gateway, it is more necessary than ever to provide care in service networks, since PHC must comply with three functions in the networks, namely, resolution, coordination and accountability<sup>22</sup>. In addition, UBS must be prepared to address urgent and emergency situations, so that users’ views and assessments no longer regard PHC as a failure.

Recognizing and having equipment, as well as knowing how to intervene in urgent situations are sine qua non conditions for the PHC team to attend urgencies. However, it is common for professionals to fail to recognize an emergency and to understand ESF, for example, as a viable service for urgent care, believing that this type of care deviates from PHC’s governing principle and therefore uses referrals as a way of solving these situations<sup>23</sup>.

### Integrity of care

Opinions on a resilient PHC prevailed, meeting the principles and guidelines proposed by the PNAB<sup>5</sup>, which affirms the function of receiving and effectively resolving the needs brought in by the people serviced.

It is an information that contrasts, for example, with what was addressed by the users who cannot easily access services as they would like to (as stated in the variable already discussed). While PHC has not provided them with facilitated access conditions according to their different realities, services have been resolving for most respondents in both settings.

On the other hand, the opinion of users who “never” or “almost never” are questioned about

other issues besides the one that motivated the consultation points out a possible gap in the health care provided to these SUS users.

This is in line with findings of a study by Catanante *et al.*<sup>24</sup> carried out in this same RRAS, with data from users interviewed in PMAQ Cycle I, where 26% never or almost never felt comfortable talking to the team about concerns, psychosocial problems and others, 30% were never or almost never asked about health needs other than the reason for their consultation, and among the users interviewed who had already undergone pregnancy, 32% were asked by the team about postpartum emotional issues. This points out that psychosocial care needs of users in PHC have been incipiently noted, investigated and fulfilled.

It is widely recognized that diverse contexts of SUS are traversed by a chronic incipience in addressing psychosocial needs of its users. Sometimes, these needs are understood as unique to the levels of secondary and tertiary care, breaking with the family-and community-centered PHC concept, by being humanized and capable of accommodating and conducting the health demands of its users in their entirety.

Differently, a study by Brandão *et al.*<sup>13</sup> adopted the Relationship and Communication indicator, which obtained the highest level of “very good” response, when addressing professionals’ interest in users (39%). It also showed a variable on the user feeling at ease with doctors, with 38% of satisfied users.

### Coordination of care

In this setting, noteworthy is that the UBS practice of scheduling consultations is found in more than half of users. This practice requires, among others, the coordination of networking, implying efficient communication channels and knowledge and recognition of the several network points with their respective functions and provisions. Universality and equal access are thus ensured in other parts of the network.

This does not apply to 40% of users who receive the UBS referral card and should seek services and professionals to whom they were referred or of their own choosing. Here, coordination of care can occur through truncated means, not necessarily aligned to network care. Users often end up not reaching the destination of the referrals when they are not scheduled and informed by the originating service.

According to Mendes<sup>25</sup> the lack of communication between PHC and other services, barriers

to access specialized services and the users’ lack of a sense of continuity of care, among other aspects are manifestations of poor or even absent PHC coordination, which is one of the most acute problems of health systems. Users who travel alone between different health care points end up being subjected to wrong diagnosis and/or treatment and under-provision of services.

We stress the importance of integrating and strengthening networks so that the coordination of care, emphatically provided by the PHC, can overcome the fragmented health system (configured by points that do not communicate with each other), starting to deal better with the chronic conditions of the population, risk factors arising from social conditions and concentration of health spending and risks at certain points of care<sup>25</sup>.

As for the integration of the teams into the territories and home visits, we observe that the ACS play an active role in the daily life of its users and services guided by the conceptual logic of the ESF.

Considering that this is the predominant logic in SUS PHC services, the positive percentage endorses, at least in this RRAS, that the transition of the PHC model has reached the population under the brand of capillary contact provided by the ACS, although users’ data were not collected with regard to the types of activities that ACS perform during visits and whether they address the health needs of the community.

The contrast with the percentage of users who have been visited by other professionals in the team corroborates a setting in which most of them cannot exit the UBS loci to perform health care, which implies a difficult integration with the families and communities in which they are inserted, since the reality of their territories is beyond the physical delimitation of the facility and those who arrive there.

According to the PNAB<sup>5</sup>, among other attributions, it is not only incumbent upon the ACS but also all professionals “to participate in the process of territorialization and mapping of the team’s area of activity, identifying groups, families and individuals exposed to risks and vulnerabilities”, although the care of the population ascribed is suggested by the same policy as occurring “primarily within the health unit and, where necessary, at home and in other community spaces (schools, associations, among others).”

It is thus a framework in which users can establish some contact with teams outside the UBS. However, the quality of the contact that teams,

in turn, have established with their users is questionable.

### Final considerations

Listening and encouraging voicing of the social subjects involved in the PMAQ and other public policies is powerful in the face of different targets and SDGs, more emphatically SDG 3, and the establishment of partnership with society, as required by SDG 17.

The feedback of information from socially participatory processes to the political, institutional and societal spheres can help in the reflection and implementation of the projects and objectives indicated by the 2030 Agenda, promoting health and the right to the city. As pointed out by Caccia Bava et al.<sup>26</sup>, the co-construction of the evaluation process with the stakeholders involved

must integrate different interest groups, so that the information can be considered important insofar as it produces meanings and is agreed upon and renegotiated by these different social stakeholders involved. It is also necessary to value and strengthen physical structures and the interaction, articulation and exchange flows between partners for the planning and implementation of projects such as the SUS.

In the face of not uncommon consideration of this project as utopian, we conclude this reflection from Lefebvre<sup>3</sup>: “Utopia must be considered experimentally, studying its implications and consequences in practice. These may surprise. Which are and will be socially successful places? How can we identify them? Under which criteria? What daily life rhythms are inscribed, written and prescribed in these “successful” places, that is, in these places favorable to happiness? That is what matters.”

### Collaborations

GV Catanante and MCGG Caccia Bava participated in all the stages of the research. LB Hirooka and HS Porto contributed to the organization and discussion of data and paper drafting.

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