Participation, representation, and deliberation in the decision-making process of the Municipal Health Council of Marabá-PA (2018-2020)

Participação, representação e deliberação no processo decisório do Conselho Municipal de Saúde de Marabá-PA (2018-2020)

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ABSTRACT The objective of this article is to analyze the decision-making process of the Municipal Health Council of Marabá (CMS-M), in the state of Pará, in the period of 2018 to 2020, focusing on the themes that were discussed in the regular meetings that took place during such period. The case study was used as a research method with a qualitative approach that combines primary and secondary sources. The primary sources were obtained through participant observation in the meetings held at the CMS-M and the secondary sources through the analysis of public documents, especially 'guidelines' and 'minutes' produced. This method is linked to its analysis model, conceived within the scope of this article. As results, the following was found: effective participation of councilors in the deliberative process; institutional rules restricting society's participation in filing claims and complaints; strong influence of municipal management in the decision-making process of the council; and low response from the municipal government in complying with the deliberations produced in the CMS-M.

KEYWORDS Health planning councils. Social participation. Deliberations. Health manager.

RESUMO *O objetivo deste artigo foi analisar o processo decisório do Conselho Municipal de Saúde de Marabá (CMS-M), no estado do Pará, no período de 2018 a 2020, tendo como foco os temas que foram discutidos nas reuniões ordinárias ocorridas nesse intervalo. Foi utilizado o estudo de caso como método de uma pesquisa de abordagem qualitativa que conjuga fontes primárias e secundárias. As fontes primárias foram obtidas por meio da observação participante nas reuniões realizadas no CMS-M, e as fontes secundárias, mediante análise de documentos públicos, especialmente 'pautas' e 'atas' produzidas. Tal método está vinculado a um modelo de análise próprio, concebido no escopo deste artigo. Como resultados, foram constatadas: efetiva participação dos conselheiros no processo deliberativo; regras institucionais restritivas à participação da sociedade na apresentação de demandas e denúncias; forte influência da gestão municipal no processo decisório do conselho; e baixa resposta do poder público municipal no cumprimento das deliberações produzidas no CMS-M.*

PALAVRAS-CHAVE *Conselhos de saúde. Participação social. Deliberações. Gestor de saúde.*

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Introduction

The participation of society in public policy management councils has been pointed out by different authors as one of the main institutional experiences developed after the 1988[1-4] Constitution. The health sector advanced the most, building a network of councils (national, state and municipal), which, in the last census study published, combined more than 50,000 health counselors, of which about 35,000 represented users and workers of the Unified Health System (SUS)[5].

In this context, the study of articles that analyze the functioning of the councils, their structure, the participation and representation of the segments that compose them, their deliberative capacity and other essential themes would represent the best strategy to build an evidence-based analysis of the situation of the health councils in Brazil. Consequently, such studies, even if indirectly, could also reveal important local health problems, allowing a better understanding of the health situation of this very different set of municipalities that Brazil has[6].

However, a survey in the SciELO database shows that, on May 17, 2021, using 'conselho' and 'saúde' as search terms, only 32 articles are dedicated to studying the performance of health councils, of which only 2 refer to councils in the North region. Expanding the search with the use of 'conselhos', only one more article is included, reaching a total of 3 articles on health councils in the North region.

This article points out this Brazilian scientific gap, intending to contribute, simply and within its limits, to its filling. To do so, it addresses the role of the Municipal Health Council of Marabá (CMS-M), in the state of Pará, in the Brazilian Eastern Amazon.

Marabá was founded on February 27, 1923, with 283,542 inhabitants. A 'pole' city in the Southeast Pará region, it is the fourth most populous municipality and third in the ranking of the largest Gross Domestic Products in the state of Pará. In demographic terms, it presents a great miscegenation of people and cultures, as the meaning of its name already indicates: 'son of the mixture'. It is known as 'Poem City', as its name is inspired by the literary work 'Marabá', by Gonçalves Dias[7].

The municipality is located in one of the areas most modified by the developmental policy implemented in the eastern Amazon region in the 1970s[8] and in the first two decades of the 21st century[9]. Such policies promoted, on the one hand, economic and social development and, on the other hand, the unequal occupation of the territory, the intensification of disputes over lands traditionally occupied by traditional peoples (indigenous, riverine and quilombola) and harmful interventions to the environment.

This transformed the way of life and the political, social and cultural processes of the city, at the same time favoring the emergence of resistance movements, in particular, the right to access basic services, such as health, education, housing and, in particular, access to land.

In the health sector, according to data made available by DataSUS (http://www2.datasus.gov.br), in 2018 and 2019, there were 32,661 hospitalizations, mainly due to: pregnancy, childbirth and puerperium (37.8% of the total of hospitalizations); injuries, poisoning and some other consequences of external causes (13.9%); digestive system diseases (11.5%); respiratory system diseases (7.03%); circulatory system diseases (4.24%); and diseases of the genitourinary system (3.53%).

In the same period, there were 3,275 deaths, with emphasis on: a) external causes of morbidity and mortality (25% of deaths); b) diseases of the circulatory system (21.3%); c) diseases of the respiratory system (8.6%); d) neoplasms (5.6%); e) infectious and parasitic diseases (4.9%); and f) diseases of the digestive system (4.76%).

The COVID-19 pandemic has impacted the municipal health system, according to data published by the Marabá City Hall on December 31, 2020, which indicate the

infection of 11,402 people and 235 deaths with a fatality rate of 2.06%, considering the confirmed cases[10]. The SUS network, on that date, had 28 beds in Intensive Care Units (ICU)/COVID, with an occupancy rate of 85.7%, with 12 beds with patients from the municipality and 12 from other cities, which demonstrates the regional relevance of Marabá in the availability of health services and equipment to the surrounding municipalities[11].

Given this scenario, it is adopted as hypothetical reasoning that the CMS-M has, throughout 2018 and 2020, included in its decision-making process, in some way, an important part of the problems mentioned above, deliberating on them and, therefore, on municipal health policies.

Thus, the objective of this article is to analyze the decision-making process of the CMS-M, from 2018 to 2020, focusing on the topics that were discussed at the ordinary meetings that took place in that interval. In order to deepen this analysis, we will seek to understand the performance of the different segments represented on the council in the aforementioned debates (participation), with emphasis on the representatives of SUS users and health workers (representation) and on the approval of the Council's deliberations by the Executive Power (deliberation).

Methodological aspects

To achieve the objective of the article, the case study was chosen as a method of a qualitative approach research, which combines primary and secondary sources, approved by the Research Ethics Committee of the National School of Public Health Sergio Arouca (Ensp)/Oswaldo Cruz Foundation (Fiocruz), under number 27694720.0.0000.5240.

The secondary sources were the 'Agendas' and 'Minutes' of the ordinary CMS-M meetings held between August 2018 and July 2020, which, until then, were equivalent to all meetings held by the current formation of the Council. On March 23, 2020, through Decree nº 26, the Municipal Prefecture took social distancing measures because of COVID-19. In compliance, the Board interrupted the face-to-face meetings from March 23, 2020 until July 31, 2020, holding, in that period, a single virtual meeting, in April 2020.

The minutes and agendas, public documents, were requested from CMS-M on March 11, 2019; February 18, 2020 and May 8, 2020, and received on April 15, 2019; June 8, 2020 and October 27, 2020.

As the aforementioned meetings are open to the public, the main author of the article participated, as a listener, in the meetings that took place between August 2019 and March 2020, applying the technique of participant observation. It is important to highlight that, following research ethics, the presence of the researcher in the field was informed to the President of the CMS-M and, by him, clarified to the plenary of the Council.

Participation, representation and deliberation: improving democracy

The discussion on participation, representation and deliberation needs to be contextualized within the scope of the democratic framework. It is worth noting that our intent is not to exhaust the debate on democracy, adopting as a strategy the focus on the aspects that build the theoretical framework of the article.

The starting point – not the arrival point – of this discussion is the polyarchic model of Dahl[12], which presents two axes: participation and liberalization (or institutionalization). In it, a society is so much more democratic the greater the number and diversity of citizens participating in the political process in institutions legitimized by society.

In this sense, the democratic advance must favor and guarantee the contestation, the

debate among those who think differently. Therefore, participation must be encouraged and guaranteed, with emphasis, above all, on those who oppose those in power. The guarantee of the opposition's participation rights, especially when minority, is thus the main indicator of the degree of democratization of a society.

This formalist conception of democracy is capable of defining, for the purpose of this article, the bases of its debate. The main criticism leveled at it is that it does not directly address social rights as the basis of democracy. It is considered here that such criticism is pertinent and, therefore, it seeks to articulate the polyarchic proposal to the valorization of social rights, with a focus on the right to health.

Dahl[12] thinks of citizens' participation in politics from the point of view of representative democracy, valuing, as fundamental institutions, the three autonomous powers (Executive, Legislative and Judiciary) functioning in a system of checks and balances; the freedom and autonomy of action of political parties from all ideological spectrums of society, especially those who are opposed to those in government; and the periodic and permanent holding of universal elections, free from influences (coercive, patrimonial and/or financial) and in which all political sides participate without restrictions and external interdictions. In this way, the participation of citizens occurs, above all, through the vote, the voter's (represented) delegation of their decision-making power to an elected (the representative).

This form of democracy faced a crisis from the 1960s onwards, when, in different ways and in different societies (particularly European and North American), those represented began to question intensely the actions of elected representatives, considering that it moved away from the interests manifested in the vote, which creates the risk of delegitimization[13].

The so-called 'crisis of representative democracy' still seems not to have been overcome, given the abstention of 66% of voters in the French elections of June 2021[14], whose main reason pointed out by analysts is precisely the disbelief in representation, a situation that repeated, in to a greater or lesser extent, what happened in the European elections of 2019[15] and the Brazilian elections of 2018[16].

For Pitkin[17], representation, because it is a contradiction in itself (to represent is to make those who are not present present), introduces in the decision-making process the need for the representative to decide whether his action should meet the interests of those who elected him ('mandate stance') or what it considers to be the general interest ('autonomy stance'), instituting the 'mandate-autonomy controversy'.

When representatives constantly opt for the 'mandate stance', they tend to distance themselves from the interests of their constituents, who respond with disbelief that, maintained over time, tends to move from the represented to their party, from this one to the other parties and from there to the electoral process itself.

Miguel[18], similarly, considers that, in a representative democracy, the formation of a political elite produces a specialization of decision-makers that separates representatives from the represented, generating the possible rupture of the links between the will of the represented and that of the representatives. As a result, there is a great distance between electoral promises and the policies adopted by the elected.

Faced with this distance, different societies can produce different proposals to overcome this threatening distance between representatives and represented. Among these, the praxis of a participatory democracy emerges, in which citizens not only act in electoral processes, but also in the decision-making process of public policies. For its advancement, it is necessary to design institutions that, without dispensing with the institutions of representative democracy[19], enable the participation of representatives of civil society directly in the decision-making process of public policies.

For Ball[20], this decision-making process is formed by a set of steps that are synergistically articulated in cycles, the 'policy cycle'. Based on this reference, it is adopted here, in a modeling way (the practice of each policy is the one that gives the final design), that such a cycle begins at the stage of agenda formation, goes through the stages of formulation, implementation, execution, monitoring and evaluation, the results of which contribute to the (re)formulation, and/or the improvement of implementation and execution, and/or impact on political agendas, in a cycle that can last as long as the policy is in force.

Thus, the institutions of participatory democracy must promote the participation of citizens in the different stages of the policy cycle, considering, in this text, the emphasis on the stages of agenda formation and formulation.

Avritzer[3(45)] defines these participatory institutions as "different ways of incorporating citizens and civil society associations in deliberation about policies [...]" that need, in order to be created and legitimized, of: i) innovation in institutional design; ii) civil society organization; and iii) the government's political will.

For Lüchmann[21], in these institutions, political decision-making is self-presented and part of those directly submitted to public debate, accepting the criterion of legitimacy of the political decision-making process as supported by the participating entity.

In order for these institutions of participatory democracy to really introduce innovative designs, their decision-making process must also assume peculiar characteristics, combining the search for consensus and voting. Manin[22] conceives deliberation as the practice of such a decision-making process. Recognizing that deliberation, in the democratic literature, is understood both as the decision itself and as the process of seeking consensus, he argues that the deliberative process of a deliberative institution must submit the decision to the process of discussion and the search for consensus.

Thus, it deepens the position of Habermas who states "[...] the deliberative model... more interested in the epistemic function of discourse and negotiation than in rational choice or political ethos"[23(11)].

Fung[24], discussing the praxis of participatory institutions, produces a typology in which he considers that the institutions that have greater deliberative capacity are those that work with a smaller number of participants, since it is in this context that the search for consensus tends to be more successful.

The author calls this type of participatory institutions 'mini-publics', showing in his analysis that: i) the transaction costs of producing consensus rise according to the number of participants, making deliberation difficult and, in the extreme, unfeasible; and ii) participation does not exclude representation, on the contrary, it forces its improvement at the risk of reifying the crisis of representation.

The challenge for participatory institutions is to be legitimized by representative institutions. In certain situations, the representatives of such institutions may consider that their decision-making power is being usurped by them[25] and react, either by restricting the operating conditions (structure, resources and autonomy), or by diverting the political agenda to other institutions or not accepting their deliberations at all.

Despite the reasons for such reactions, what structure them is the denial of the deconcentration of power (decision-making, resource allocation, policy formulation) from traditional institutions to new institutions. When this reaction occurs in the Executive Branch, it reifies a concentration-oriented characteristic already defined as ultra-presidentialism[26]. The challenge, therefore, is to produce a balance between the different institutions that must set the stage for the decision-making process.

Briefly, this is the theoretical framework that underlies the analysis model that will be applied. In the following topic, we will seek to show how such reflections can be applied to health councils (and, by extension, to other

public policy management councils and even to other participatory institutions), concluding the model, which will be applied to the CMS -M in later threads.

Analysis of participation, representation and deliberation in Municipal Health Councils

Several authors have studied health councils. From the pioneering work by Carvalho[27] to the recent ones[28], and most of them approach, more or less broadly, the conception, functioning and limits of councils, either in a more essayistic way[29-32], or through case studies[33-35].

The study of these works (and of several others whose space in the article does not allow to cite) contributed to the elaboration of the theoretical model presented above; and for its practical part, it begins to be discussed here through a reflection that articulates the work of Moreira and Escorel[36] and Rezende and Moreira[37].

Moreira and Escorel[36] developed their model in 2007 to analyze the set of Brazilian health councils, since they coordinated the only census study in the country on municipal and state health councils, which were analyzed on three dimensions: i) Autonomy (physical structure, human and financial resources); ii) Organization (meetings, training and internal instances); and iii) Inclusiveness (how the President is chosen and the society's participation in the meetings).

Cities with a population size similar to that of Marabá (250,000 to 500,001 inhabitants) had positive performances in the three dimensions of the study, surpassing the performance of smaller cities, but being below those with a larger population, especially those with between 500,001 and 1,000 .000 inhabitants. Altogether, the authors work with 18 indicators – which will be presented in the topic about the CMS-M – for which cities with a similar size to Marabá had, on average, a positive performance in 13, with a negative emphasis on financial, human resources and training.

The same authors also include in their analysis the year of creation of the council, the parity, the entities that make up the segment of users and workers and the approval or not of their deliberations by the Executive Power. In this work, therefore, there is a proposal for a study on participation.

Rezende and Moreira[37] start from this model, but seek to add dimensions that allow a more specific analysis, since they carry out a case study in the council of the municipality of Rio de Janeiro, focusing on representation and, in the aspects that are of interest here, on the deliberation.

These authors studied the role of counselors in ordinary meetings, analyzing it from a typology of their interventions – voting; informative; vocalizer; demanding and evaluative – which will be adapted here to capture the clashes between the different segments.

Now, we move to the study of the performance of the CMS-M.

The Municipal Health Council of Marabá: performance 2018-2020

The CMS-M was created on July 5, 1993 (Municipal Law nº 13.104/1993), however, its Internal Regulation (RI) was only approved in 2014 (Resolution nº 15, of July 17, 2014). In 2007, the City Hall dismissed the CMS-M, alleging that its performance hindered the management. This situation lasted until 2015, when the Public Ministry of the State of Pará re-established the functioning of the Council[33].

Regarding infrastructure and human resources, it was only in 2018 that the CMS-M started to have its own headquarters, located in the Nova Marabá nucleus. This headquarters has a room for the presidency, space for

thematic committees and an auditorium for holding collegiate meetings, with furniture, computers, telephone lines, internet access. The Support Team is made up of 9 public servants: 2 concierge agents, 2 responsible for cleaning, 2 in the administrative area, 1 driver and 1 executive secretary.

The CMS-M is composed of 20 full members and 20 alternates (representing the same entities as the members) who, respecting the principle of parity, have a two-year term of office with the right to unlimited renewals (Municipal Law nº 13,914, of 1996).

Box 1 illustrates the current composition of the CMS-M, which started in 2018. It can be seen that the segment of health workers is composed of four entities, since, at the Municipal Health Conference of 2018, there were no interested entities in the fifth opening. By drawing lots, the Regional Council of Dentistry obtained the right to be represented by two counselors. It is also noticed that private providers do not occupy any openings.

Box 1. Entities that make up the CMS of Marabá in the Biennium: 2018-2020

Segments	Entitites
SUS users (10 openings)	(U1) Project Better Future Assossiation / replaced by the Marabá Municipal Servants Union - SERVIMAR
	(U2) Youth Institute of the Carajás Region - IJURC
	(U3) Better life Support House - CAVIM
	(U4) Paraense Association of Hemophilia and Coagulopathies
	(U5) Association of residents of the Vale do Itacaiunas neighborhood - AM-BAVI
	(U6) 'Recanto Feliz da Folha 31' Association
	(U7) Hozana Lopes de Abreu Cultural Institute
	(U8) Reviver Institute
	(U9) Live Woman Institute
	(U10) Community Association of Residents of the Araguaia neighborhood - Ascomba
Health Workers (5 openings)	(T1) Nurses Union of the State of Pará - SENPA
	(T2) Health Workers Union of the State of Pará-Sindsaúde-PA
	(T3) Pará's medical doctors union - SINDMEPA
	(T4) Regional Council of Dentistry - CRO (2 places)
Managers and Private Providers (5 openings)	(G1) Municipal Health Secretariat of Marabá-SMS-M (4 places)
	(G2) 11th Regional Health Center/SESPA/Marabá-PA

Source: own elaboration based on data obtained from the Municipal Health Council of Marabá[38].

It is important to highlight that, in *box 1*, the entities were identified by a coding composed of a capital letter and a number (for example: (U1) Associação Projeto Futuro Melhor). This coding will be resumed in *box 2*, enabling its construction and presentation.

The CMS-M has its own budget (R$ 164 thousand in 2018; R$ 550 thousand in 2019 and R$ 150 thousand for 2020), Board of Directors (BOD), Executive Secretariat and Permanent Commissions: administrative, technical, bidding and evaluation of primary care.

The law that created the CMS-M defined the Municipal Health Secretary as the natural president of the Council, a situation that was modified in August 2000, by Law nº 16,489, which defines the election with direct and secret vote of the titular councilors (in their absence, of alternates) as a means of choosing the president. Currently, the presidency is held by a counselor who represents health workers.

The BOD elected for the 2018/2020 biennium is mostly represented by the segments of users and health workers, who occupy three of the four available vacancies, including the presidency and vice presidency.

CMS-M holds regular monthly meetings, open to the public, but its IR defines that, in order for the public to exercise the right to voice, prior approval by the Plenary is required. In the period studied, 25 ordinary meetings were held, putting on the agenda and discussing 126 points. *Table 1* systematizes these agenda items, categorizing them into 3 major Themes (F-SUS: Functioning of the SUS; F-CMS: Functioning of the CMS-; and D-POP: Complaints from the Population) and 13 Sub-themes.

Table 1. Agenda Points discussed at the CMS-M Ordinary Meetings, distributed by Themes, Sub-themes and Year of the Meeting. August 2018 to July 2020. (n=126)

		AGENDA POINTS DISCUSSED							
THEME	**SUB-THEME**	**2018**	**%**	**2019**	**%**	**2020**	**%**	**TOTAL**	**%**
F-SUS:		4	3.17	17	13.5	4	3.17	25	19.84
Functioning of the SUS	All-nighter program	-	-	2	1.59	-	-	2	1.59
	Laboratories	1	0.79	2	1.59	-	-	3	2.38
	Health units	1	0.79	2	1.59	2	1.59	5	3.97
	Health workers	1	0.79	3	2.38	1	0.79	5	3.97
	Outsourcing of services	1	0.79	8	6.35	1	0.79	10	7.93
F-CMS:		17	13.5	47	37.3	17	13.5	81	64.29
Functioning of the CMS-M	Training	8	6.35	5	3.97	2	1.59	15	11.91
	Mangement of CMS-M	7	5.56	23	18.26	13	10.32	43	34.13
	Replacement of representatives of the Entities	-	-	12	9.52	2	1.59	14	11.11
	Oversight	2	1.59	7	5.55	-	-	9	7.14
D-POP:		1	0.79	16	12.69	3	2.38	20	15.87
Complaints from the Population	Medical procedures	-	-	2	1.59	1	0.79	3	2.38
	Access to health care								
	Health Units	1	0.79	4	3.16	2	1.59	7	5.55
	Public transparency	-	-	5	3.97	-	-	5	3.97
TOTAL		22	17.46	80	63.49	24	19.05	126	100

Source: own elaboration based on the analysis of the Agenda of the Ordinary Meetings of the CMS-M[38].

Of these 126 agenda items, 54 (42.8%) produced, throughout the deliberation process, debates among the Board Members. *Table 2* presents the dynamics of these debates with regard to the entity that proposed the agenda; the way – convergent or divergent – in which the other entities of the CMS-M positioned themselves in the debate of the proposals; and the outcome of the deliberative process, that is, whether or not the proposed agenda was approved. When entities did not manifest, the sign '-' was assigned.

Table 2. Debates generated by the Agenda Points at the CMS-M Ordinary Meetings between August 2018 and July 2020: distribution by entities and their segments, proponents, divergent and convergent positions and whether the agenda was approved or not. (n=54)

	Positioning in relation to the guidelines			Result of the deliberative process		
				Item Approved?		
Entities and ther segments	**Proponent**	**Convergent**	**Divergent**	**Yes**	**No**	**Total**
Users	**13**	**47**	**31**	**8**	**5**	**13**
Project Better Future Assossiation / replaced by - SERVIMAR	1	9	3	1	-	1
Youth Institute of the Carajás Region - IJURC	-	4	1	-	-	-
Better life Support House - CAVIM	-	-	-	-	-	-
Paraense Association of Hemophilia and Coagulopathies	2	3	3	-	2	2
Association of residents of the Vale do Itacaiunas neighborhood - AMBAVI	-	4	8	-	-	-
'Recanto Feliz da Folha 31' Association	1	1	1	1	-	1
Hozana Lopes de Abreu Cultural Institute	3	5	3	2	1	3
Reviver Institute	3	14	8	2	1	3
Live Woman Institute	3	5	4	2	1	3
Community Association of Residents of the Araguaia neighborhood - Ascomba	-	2	-	-	-	-
Workers	**9**	**30**	**30**	**5**	**4**	**9**
Nurses Union of the State of Pará - SENPA	4	4	7	1	3	4
Health Workers Union of the State of Pará-SINDSAÚDE-PA	2	14	11	2	-	2
Pará's medical doctors union - SINDMEPA	2	5	4	2	-	2
Regional Council of Dentistry - CRO	1	7	8	-	1	1
Manegement	**20**	**7**	**6**	**17**	**3**	**20**
Municipal Health Secretariat	20	4	5	17	3	20
11th Regional Health Center/SESPA/Marabá-PA	-	3	1	-	-	-
Service Providers	**-**	**-**	**-**	**-**	**-**	**-**
(NO possui representantes nesta gestão)	-	-	-	-	-	-
Board of Directors	12	-	-	7	5	12
TOTAL	**54**	**84**	**67**	**37**	**17**	**54**

Source: own elaboration.

Box 2 deepens this scenario. Its purpose is to map, in the clashes that took place during the deliberation and decision-making process on the 54 proposals presented in *table 2*, the convergences and divergences between the entities that make up the CMS-M and, therefore, the segments represented in it. Note that the proposals are classified by the themes presented in *table 1* and that the Entities are identified by the codes in *box 1*.

Box 2. Decision-making process of the CMS-M, July/18 to August/2020: debated proposals distributed by the proposing entities, converging and divergent positions of the entities, topic to which the proposals refer and approval or not by the full CMS-M. (n=54)

PROPOSALS	Prop*	Convergent Position	Divergent Position	APRV**	Theme
1. Accreditation of specialized services	G01	U09	U01; U05; T04	YES	F-SUS
2. Reorganization of Service Protocol of the Municipal Hospital	G01	U07	T02; T04	YES	F-SUS
3. Authorization for the participation of the Nursing Congress	G01	U05; U07; T03; T04; G02	U08	YES	F-CMS
4. Implementation of all-nighter dental care in the Basic Health Unit	G01			YES	F-SUS
5. Creation of the planning equity committee of 2019	G01	T01		YES	F-CMS
6. Request of the copy of the minute book of the frequency of the counselors	G01	U10	T02	YES	F-CMS
7. Unilateral cancellation by SMS-M of Night Service in Units (All-nighter Program)	G01		04; U05; U06; U08; U09; T02; T03; T04	NO	F-SUS
8. Presentation of the proposal of internal regulations of the Municipal Health Plenary	G01			YES	F-CMS
9. Return of the operation of the municipal hospital and municipal maternity laboratory	G01	U07		YES	F-SUS
10. Presentation of the Complementary Table and Accreditation of Elective Surgery	G01	U05; U08	T01; T3	YES	F-SUS
11. Accreditation process for hiring legal entity: diagnoses in clinical laboratory	G01	U02; T04	U04; U05; U08; U09	NO	F-SUS
12. Contractual additives of accreditation for technical services specializes in anestesiology	G01	U02; U04; U07	U08; U09; T02; T04	YES	F-SUS
13. Contractual additives of accreditation for specialized technical services: diagnostics in clinical laboratories	G01	U02; U04; U07; U08; U09	T02; T04	YES	F-SUS
14. Contractual Additives of Accreditation for Technical Services Specialized in Orthopedics and Traumatology	G01	U02; U04; U07; U08; U09; T02; T04		YES	F-SUS
15. Authorization for the implementation of 1 family healt program team in the rural area of the municipality, in Pastor Jonatas Azevedo emegency room	G01	U08; U09. T02; T04		YES	F-SUS
16. Management Reports - Accountability from 2011 and 2012	G01	U03; U08; U09	T02	YES	F-CMS

Box 2. (cont.)

PROPOSALS	Prop*	Convergent Position	Divergent Position	APRV**	Theme
17. Complementary table to the values of the SIGTAP/ SUS table	G01	G02	T01; T02; T04	YES	F-SUS
18. Municipal Operative Plan for Integral Health Care for Adolescents In Conflict With the Law	G01	G02	T01; T02	NO	F-SUS
19. Judgment of fiscal accountability - Management Reports 2013 and 2014	G01		T02; T04	YES	F-CMS
20. Petition for reevaluation of health management fiscal accountability from 2015 and 2016 that had been rejected	G01	U08	T01; T02	YES	F-CMS
21. Expert report for the adequacy of hazardous-work granting for health workers	T01	703		NO	F-SUS
22. Report on withdrawal of hazardous-work grants of salaries without expert report	T01		U05; U08; T02; T03	NO	F-SUS
23. Creation of a Commission to propose amendment of the Internal Regulations and amendment of the CMS-M Law	T01			YES	F-CMS
24. Complaint about carrying out medical shifts in disagreement with the legislation	T01	T02; G02		YES	D-POP
25. Recomposition of the CMS-M Ethics Committee	T02	U09		YES	F-CMS
26. Proposal for the extension of mandate of the counselors for 1 year-Motivation: COVID-19 pandemic	T02	U09; T01		YES	F-CMS
27. Request for refunds to participate in the Pan American Congress of Medicine	T03			YES	F-CMS
28. Emergency hiring of doctor on duty for municipal hospitals	T03	T02; T04; G01		YES	F-SUS
29. Denounces: asks for justifications of management for the hiring of dentist without public-service exams	T04	U08; U09; T02; T03	G01	NO	D-POP
30. Participation of Counselors at the National Health Conference	U01	U08	U04	YES	F-CMS
31. Denunciation of non -functioning of the health units of the neighborhoods: Paz and Coca Cola	U04			NO	D-POP
32. Technical Visit of Inspection to the headquarters of companies of the health area in service to the Municipality	U04	T02; T03; T04	U02; U08; G01	NO	F-CMS
33. Participation of the plenary counselors of the 13th State Health Conference	U06	U05; U08; U09; T02; G01		YES	F-CMS
34. Participation of the 12th Brazilian Congress of Collective Health Abrasco	U07			YES	F-CMS
35. Members of the Bidding Committee requests to participate in a Course of Contracts and Agreements in Belém	U07			YES	F-CMS
36. Situation of the Municipal Hospital/Marabá laboratory - not performing the exams at the hospital itself - outsourcing	U07			NO	F-SUS
37. Complaint. Lack of working conditions of de Worker's Health Dpto. - VISAT	U08	T02; T04		NO	D-POP
38. Request for provisional removal of the president of CMS-M to analyze irregular acts	U08		U05; U07; T01; T03; G01; G02	YES	F-CMS

Box 2. (cont.)

PROPOSALS	Prop*	Convergent Position	Divergent Position	APRV**	Theme
39. Definitive removal of the president of CMS-M for illegalities practiced	U08	U01	U05; U07	YES	F-CMS
40. Complaint - Reviver Institute Counselor was a candidate for elective office and did not depart from the duties of Health Counselor	U09	U01; U10; T02	U07; G01	YES	D-POP
41. Request of the vehicle for travel to participate in the 13th State Health Conference	U09			YES	F-CMS
42. Denunciation of lack of medicines for high-blood pressure, diabites and others in the health unit Amadeu Vivacqua	U09			NO	D-POP
43. Invitation to participate in a meeting with the CES-Pará Board of Directors	MD		U09; T02	YES	F-CMS
44. Denunciation of a user who reports that he needs cancer treatment outside the home	MD	T03		NO	D-POP
45. Creation of an organizing committee to carry out the health plenary	MD			YES	F-CMS
46. Creation of a Provisional Committee to monitor the audit at SMS-M to determine complaints	MD	U05; U08; U09; T01; T02		YES	F-CMS
47. Invitation from the Health Secretariat of Curionópolis-PA to participate in the Municipal Health Conference	MD		U01; U03; T01; T02	YES	F-CMS
48. Participation of a meeting in CES-Pará	MD	U01; U06; U08; T01		YES	F-CMS
49. Request to participate in bidding course	MD	G01	U08; U09; T01; T04	NO	F-CMS
50. Contracting of legal and accounting advice to advise the CMS-M	MD	U08; T02	G01	YES	F-CMS
51. Complaint: No surgical procedure	MD			NO	D-POP
52. Complaint about medical conduct in delivery	MD			NO	D-POP
53. Making informative banners for the dissemination of the work of CMS-M	MD	U08; T02		YES	F-CMS
54. Indication of representatives to participate in the 10th CISTTÃO in Brasília-DF	MD			YES	F-CMS

Source: own elaboration.

* Proponent **Approval by the Full CMS-M.

Closing this topic, *table 3* focuses on the 54 agenda items that generated debates in the monthly meetings of the CMS-M, turning to the reaction of the Executive Branch to the deliberations of the CMS-M, that is, whether it ratified them or not. It is important to highlight that *table 3* resumes the distribution by themes and subthemes of *table 1*, in order to facilitate the data analysis, carried out in the next topic.

Table 3. CMS-M resolutions from August/2018 to July/2020: distribution by Themes, Sub-themes, Year and Reaction of the Executive Branch. (n=54)

		Deliberations				Reaction of the Executive Branch		
Themes	**Sub-themes**	**2018**	**2019**	**2020**	**TOTAL**	**Certified**	**Not Certified**	**No Information**
Fuctioning of the SUS	**TOTAL**	**3**	**12**	**2**	**17**	**8**	**4**	**5**
	All-nighter program	-	2	-	2	-	2	-
	Laboratories	-	2	-	2	2	-	-
	Health units	1	1	2	4	2	1	1
	Health workers	1	2	-	3	1	-	2
	Outsourcing of services	1	5	3	6	3	1	2
Functioning of the CMS-M	**TOTAL**	**9**	**15**	**4**	**28**	**8**	**4**	**16**
	Training	6	2	1	9	5	1	3
	Mangement of CMS-M	2	10	3	15	2	2	11
	Replacement of representatives of the Entities	-	-	-	-	-	-	-
	Oversight	1	3	-	4	1	1	2
Complaints from the Population	**TOTAL**	**1**	**8**	**-**	**9**	**-**	**1**	**8**
	Medical procedures	-	2	-	2	-	-	2
	Access to health care	1	1	-	2	-	-	2
	Health Units	-	3	-	3	-	-	3
	Public transparency	-	2	-	2	-	1	1
GRAND TOTAL		**13**	**35**	**6**	**54**	**16**	**9**	**29**

Source: own elaboration based on CMS-M[38] documents.

Analysis of the performance of the CMS-M 2018-2020

The current composition of the CMS-M shown in *box 1* follows the parity between users and other segments. Users by 10 entities from different areas of activity: 5 of 'gender, ethnicity and age group' (50%); 'Residents' associations' (30%); 'Institutions for people with disabilities and pathologies' (10%) and 'Education, sport and culture' (10%) complete the representativeness, which partly differs from the findings at the national level by Moreira and Escorel10 in which more than 60 % of user entities are characterized by 'Association of Residents' (25%); 'Religious Groups' (21%); and 'Worker Entities' (20%).

The segment of health workers has 5 openings filled by unions of nurses, doctors and dentists and by the State Union of health workers. 5 seats are allocated to management and private providers, 4 of which are for municipal managers and 1 for state managers.

There is a lack of private providers, which prefer to address their demands directly with managers to the detriment of participation in the political arena in the Councils[4].

The CMS-M is structured with its own headquarters, a support team of 9 servants for support and its own budget of R$ 864 thousand in the 2018-2020 triennium. It has an elected BOD for a two-year term, currently chaired by a workers' representative.

There are four permanent commissions in operation: Administrative, Technical, Bidding and Evaluation of Primary Care; composed of full and alternate directors. It also has an Executive Secretariat that provides administrative and operational advice to the Council.

The plenary of the CMS-M meets monthly, either on an ordinary or extraordinary basis, at the call of the president or by one third of the councilors. In March 2020, the mayor decreed the suspension of face-to-face meetings in

view of the need for social isolation due to the pandemic of the new coronavirus.

Of the 126 agenda items discussed in 25 plenary meetings in the period shown in *table 1*, the theme 'functioning of the CMS-M' predominates, with a total of 81 propositions, 17 in 2018, 47 in 2019 and 17 in 2020, demonstrating that the Board is self-centered, focused on issues internal to its administration.

The 'functioning of the SUS', a theme intrinsic to the strategic role of the Council, was discussed in 25 agenda items (4 in 2018, 17 in 2019 and 4 in 2020), focused mainly on the functioning and management of Health Units (structures and technicians). There is a strong trend towards privatization of health services in which the sub-theme 'Outsourcing of Services' accounted for 10 propositions.

The topics that appear least in the Council's debate are issues related to demands linked to criticism and complaints from the population (20 agenda items). Complaints are more linked to failures in medical procedures; access to health services and lack of structure of health units; which suggests precariousness in the system, especially in medium and high complexity.

In the deliberative process, of the 126 agenda items shown in *table 1*, 54 produced debates between the councilors described in *table 2 and box 2*, evidencing the reproduction of alliances between the segments and how debates are held in the CMS-M. *Box 2* clarifies that the 54 agenda items were presented by the representatives of the segments: 'Managers' (G1) - 20 proposals; BOD - 12; 'Users' (U7) – 3, (U8) – 3, (U9) – 3, (U4) – 2, (U1) – 1, (U6) – 1; 'Workers' (T1) – 4, (T2) – 2, (T3) – 2 and (T4) – 1. No agenda items were presented by: (G2), (U2), (U3), (U5) and (U10).

Of the 20 managers' proposals (G1), 17 were approved, and 3 were rejected. The proposals that were not approved were 7, 11 and 18. Of these 20, 18 are related to the functioning of the SUS, 2 about the functioning of the Council; and none of the complaints from the population were approved. Of the 20 proposals, 6 were without divergences and all were approved, and 14 with divergences; of these 14, 11 were approved and 3 were not approved. Proposal 7, which was not approved, had divergences from users U4, U5, U6, U8 and U9 and from workers T2, T3 and T4; the 11, only had divergences from users U4, U5, U8 and U9, and the 18, by workers T1 and T2.

Box 2 shows that, of the 20 proposals, there were 39 convergences against 27 divergences. Of the convergences, 3 of the managers, 28 of the users, only U1 and U6 had no convergences, and 8 of the workers. Of the 37 disagreements, 14 were from users and 23 from workers.

Of the 12 BOD agenda items, 8 were approved and 4 were not (44, 49, 51, 52). Of these 12, 9 refer to the theme 'Functioning of the CMS-M', and 3, to 'Complaints from the population'; none were approved. Of the 12 agenda items, 8 had no divergences, and 6 were approved; and 4 with disagreements – of these, 3 were approved, and 1, not approved. Proposals 44, 51 and 52 dealt with complaints, even without divergences between the segments, were not approved; 49 had disagreements from users U8 and U9, workers T1 and T4, and manager G1.

Of the 12, there were 15 convergences and 11 divergences. Of the convergences, 8 were from the user segment; 6 from workers and 1 from managers. Among the 11 disagreements, 5 were from users, 5 from workers and 1 from management.

Of the users' 13 topics, 8 were approved and 5 were not approved. Of these 13, 1 was about the 'Functioning of the SUS', 8 about the 'Functioning of the CMS-M' and 4 about complaints. Of the total, 7 were without divergences with 4 approvals and 3 disapprovals; 6 with divergences, being 4 approved and 2 not. For the non-approved points 31, 36 and 42 there were no manifestations, the 32 had support from workers T2, T3 and T4, and divergence from users and managers U2, U8 and G1; of 37, only convergent T2 and T4.

Of the 13, there were 15 convergences and 14

divergences. Of the convergences, 7 were from users; 7 from workers and 1 from managers. Among the 14 divergences, 8 were from users, 2 from workers and 4 from management.

Box 2 shows that workers presented 9 proposals, 6 of which were approved and 3 were not. Of the 9, 7 were without divergences with 6 approvals and 1 not approved, 2 with divergences and disapproved. Of the 9, there were 13 convergences and 5 divergences. The convergences were: users (4); workers (7); managers (2). Of the 14 divergences, 2 from users, 2 from workers and 1 from management.

In the management proposals, the discussions point to alignment with users, and rejection by workers, especially in proposals that restrict labor rights and the ones about outsourcing services (1, 2, 10, 12, 13, 17). User agenda items supported by workers and with resistance from the segment itself with 8 divergences; workers have signed alliances with users.

The results indicate that management and the 'BOD' exert a strong influence on the deliberative process of the CMS-M, presenting 60% of the agendas and approving 81% of their proposals. The users with 24% of proposals and 61% of approval, and the workers presented 16% of the points and had success in 66% of the deliberations.

Although private providers did not participate in the deliberative process, management presented 10 proposals for outsourcing health services; even with the workers' protest, 6 were approved, and 3 were certified, which proves the political strength of private managers in negotiations with the public power.

Table 3 proves low effectiveness in meeting the demands by the management, which certified only 16 proposals out of the 54 discussed. Of the 16 certified, 8 were on the theme 'Fuctioning of the SUS'. There is a lack of a deliberative agenda to address the main health problems faced by the population, the causes of death that occurred in the years 2018-2019 indicated by DataSUS (http://www2.datasus.gov.br) and the fight against the pandemic of COVID-19, thus dispensing with the participation of the CMS-M in the search for solutions and in the planning of actions.

On the topic 'Functioning of the CMS-M', 8 deliberations were certified and none of the 'Population Complaints', which highlights the difficulty of society's access to debates and the solution of their demands, both by the municipal health management and in the environment of the CMS-M, which, by law, is restrictive as it requires that, for the user to be heard in their demands, the prior approval of the plenary is necessary to grant/or not 'the right to speak'.

Final considerations

The results point to a low spontaneous presence of citizens/users in the CMS-M meetings, thus restricting its inclusive potential in the formulation of propositions that vocalize the expressions of society in meeting its demands and the consequent construction of significant agendas for public policies of health.

Analyzes of the decision-making process of the CMS-M indicate a wide insertion of internal themes linked to the functioning of the Council, which shows a tendency to act from an endogenous agenda. This element strengthens the idea of limits to the Council's action in relation to society's agenda.

To this, there are obstacles added to the deliberative process, as well as asymmetrical discourses, with a strong influence of municipal management in the decision-making process and low response in complying with the deliberations produced, which can incur risks of legitimizing the Council as a democratic space for public health management.

The performance of user representatives in the participatory, representative and deliberative process proved to be convergent with the SUS defense agenda, monitoring of the main health problems in the municipality and investments in the health care network; and divergent in the proposals that limited the scope of public health policies demanded

by society. The workers, on the other hand, converged on various agendas presented by users and on those referring to guarantees of labor rights; and divergent in propositions of privatization of health services and withdrawal of benefits conquered by the class.

The limitations faced refer to the period of the COVID-19 pandemic, causing the cancellation of CMS-M meetings for a significant period in 2020, whether in person or virtual, making it difficult for researchers to adopt other research techniques for improvement of the method.

Collaborators

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References

1. Gohn MG. Conselhos gestores: e participação sociopolítica. 2. ed. São Paulo: Cortez; 2003. (Série: Questões da nossa época, v. 84).

2. Tatagiba L. Conselhos gestores de políticas públicas e democracia participativa: aprofundando o debate. Rev. Sociol. Polit. 2005; (25):209-213.

3. Avritzer L. Instituições participativas e desenho institucional: algumas considerações sobre a variação da participação no Brasil democrático. Opin Publica. 2008; 14(1):43-64.

4. Labra ME. Conselhos de saúde: Visões 'macro' e 'micro'. Civitas. 2006; 6(1):199-221.

5. Moreira MR, Escorel S. Conselhos Municipais de Saúde do Brasil: um debate sobre a democratização da política de saúde nos vinte anos do SUS. Ciênc. Saúde Colet. 2009; 14(3):795-806.

6. Silva BT, Lima IMSO. Conselhos e conferências de saúde no Brasil: uma revisão integrativa. Ciênc. Saúde Colet. 2021 [acesso em 2021 jul 26]; 26(1):319-328. Disponível em: http://old.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232021000100319&lng=pt&nrm=iso.

7. Universidade Federal do Sul e Sudeste do Pará (UNIFESSPA). Sobre a cidade de Marabá. Marabá: CPEE; 2018. [acesso em 2021 jul 26]. Disponível em: https://cpee.unifesspa.edu.br/maraba.html.

8. Velho OG. Frentes de Expansão e estrutura agrária: estudo do processo de penetração numa área da Transamazônica. Rio de Janeiro: Zahar; 1972.

9. Biancarelli AM. A Era Lula e sua questão econômica principal: crescimento, mercado interno e distribuição de renda. Rev. Inst. Estud. Bras. 2014 [acesso em 2021 jul 26]; (58):263-288. Disponível em: http://old.scielo.br/scielo.php?script=sci_arttext&pid=S0020--38742014000100012&lng=pt&nrm=iso.

10. Marabá. Prefeitura Municipal. Boletim COVID-19. 2020. [acesso em 2021 jul 26]. Disponível em: https://maraba.pa.gov.br/boletim-covid-19-de-31-12-2020/.

*Orcid (Open Researcher and Contributor ID).

11. Queiroz D, Almeida C, Campos AC. Perfil epidemiológico dos óbitos por COVID-19 no município de Marabá-Pará. Revista de Saúde Pública do Paraná. 2021 [acesso em 2021 jul 29]; 3(2):107-20. Disponível em: http://revista.escoladesaude.pr.gov.br/index.php/rspp/article/view/403.

12. Dahl RA. Poliarquia: participação e oposição. São Paulo: EdUSP; 1997.

13. Manin B, Przeworski A, Stokes SC. Eleições e representação. Lua Nova. 2006 [acesso em 2021 jul 27]; (67):105-138. Disponível em: http://old.scielo.br/scielo.php?script=sci_arttext&pid=S0102644520060002 00005&lng=pt&nrm=iso.

14. Revista Exame. Revés para Macron e Le Pen em eleição com abstenção recorde na França. 2021. [acesso em 2021 jul 26]. Disponível em: https://exame.com/mundo/reves-para-macron-e-le-pen-em-eleicao--com-abstencao-recorde-na-franca/.

15. Rádio França Internacional-RFI. Abstenção pode bater recorde nas eleições europeias. 2021. [acesso em 2021 jul 26]. Disponível em: https://www.rfi.fr/br/europa/20190524-abstencao-pode-bater-recorde--nas-eleicoes-europeias.

16. Brasil. Câmara dos Deputados. Segundo turno de eleições municipais tem recorde de abstenções. 2020. [acesso em 2021 jul 26]. Disponível em: https://www.camara.leg.br/noticias/711521-segundo-turno-de--eleicoes-unicipais-tem-recorde-de-abstencoes/.

17. Pitkin HF. The concept of representation. 1. paperback ed. Berkeley: Univ. of California Press; 1972.

18. Miguel LF. Democracia e representação: territórios em disputa. São Paulo: Editora Unesp; 2013.

19. Santos BS, Avritzer L. Para ampliar o cânone democrático. In: Santos, BS organizador. Democratizar a democracia: os caminhos da democracia participativa. Rio de Janeiro: Civilização Brasileira; 2002.

20. Ball SJ. What is policy? Texts, trajectories and toolboxes. Discourse, London. 1993; 13(2):10-17.

21. Lüchmann LHH. Participação e representação nos conselhos gestores e no orçamento participativo. Caderno CRH, UFBA. 2008; 21(52):87-97.

22. Manin B. On Legitimacy and Political Deliberation. Polit. Theory, Bev. Hills. 1987; 15(3):338-368.

23. Habermas J. Comunicação política na sociedade mediada: o impacto da teoria normativa na pesquisa empírica. trad. Ângela Marque. Líbero. 2006; (21):9-22.

24. Fung A. Receitas para esferas públicas: oito desenhos institucionais e suas consequências. In: Coelho VCP, Nobre M. Participação e Deliberação. Teoria Democrática e Experiências Institucionais no Brasil Contemporâneo. São Paulo: Editora 34; 2004. p. 173-209.

25. Przeworski A. Ama a Incerteza e Serás Democrático. São Paulo: Novos Estudos CEBRAP. 1984; (9):36-46

26. Abrucio FL. O ultrapresidencialismo Estadual. In: Andrade RC, organizador. Processo de Governo no Município e no Estado. São Paulo: EDUSP; 1998.

27. Carvalho AI. Conselhos de saúde no Brasil: participação cidadã e controle social. Rio de Janeiro: IBAM; FASE; 1995.

28. Souza CMN, Heller L. O controle social em saneamento e em saúde: análise comparativa com base nos marcos legais federais brasileiros. Ciênc. Saúde Colet. 2019 [acesso em 2021 ago 16]; 24(1):285-294. Disponível em: http://old.scielo.br/scielo.php?script=sci_arttext&pid=S141381232019000100285&lng=pt&nrm=iso.

29. Correia MVC. Que controle social? Os Conselhos de Saúde como Instrumento. Rio de Janeiro: Editora Fiocruz; 2000.

30. Cortes SMV. Construindo a possibilidade da participação dos usuários: conselhos e conferências no Sistema Único de Saúde. Sociol. 2002; (7):18-49.

31. Fuks M. Democracia e participação no Conselho Municipal de Saúde de Curitiba (1999-2001). In: Fuks M, Perissinoto RM, Souza NR, organizadores. Democra-

cia e participação: os conselhos gestores no Paraná. Curitiba: Editora UFPR; 2004. p. 13-44.

32. Guizardi FL, Pinheiro R. Dilemas culturais, sociais e políticos da participação dos movimentos sociais nos Conselhos de Saúde. Rio de Janeiro: Ciênc. Saúde Colet. 2006; 11(3):797-805.

33. Cristo SCA, Figueiredo ERL. Controle social: uma análise do Conselho Municipal e Saúde de Marabá no sudeste do Pará. In: Anais do 2º Seminário de Iniciação Científica. 2016; Marabá: Unifesspa; 2016. v. 1.

34. Cárdenas AMC, Silva SR, Mello MVFA. Conselho Estadual de Saúde do Amapá: controle social como forma de empoderamento da sociedade. PRACS: Rev. Eletr. Hum. Curso de Ciênc. Soc. UNIFAP. 2011; (4):59-67.

35. Medeiros AM, Noronha NM. Conselho Municipal de Saúde de Parintins/AM: quando o Controle Social incomoda a Administração Pública. Marupiara. Revista Científica do CESP/UEA. 2018 [acesso em 2022 set 13]; (2):33-48. Disponível em: http://periodicos.uea.edu.br/index.php/marupiara/article/view/904.

36. Moreira MR, Escorel S. Municipal Health Councils of Brazil: a debate on democratization of health in the twenty years of the SUS. Ciênc. Saúde Colet. 2009; 14(3):373-381.

37. Rezende RB, Moreira MR. Relações entre representação e participação no Conselho Municipal de Saúde do Rio de Janeiro: segmento dos usuários, 2013-2014. Ciênc. Saúde Colet. 2016 [acesso em 2021 ago 16]; 21(5):1409-1420. Disponível em: http://old.scielo.br/scielo.php?script=sci_arttext&pid=S141381232016000501409&lng=pt&nrm=iso.

38. Marabá. Conselho Municipal de Saúde. Pautas e atas 2018-2020. Marabá: CMSM; 2020.

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