



Factors associated to social control practice by physical education professionals in primary health care: a national survey

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ABSTRACT. The aimed of the study was to analyze the factors associated to Social Control practice by Physical Education professionals enrolled in Family Health Support Units (NASF) in Brazil. This is a nationwide, exploratory, descriptive and quantitative study carried out in 2011 with 296 Physical Education professionals of Support Center for Family Health teams. The study outcome was the Social Control. Odds ratio was estimated to check associated factors. One third of Physical Education professionals enrolled in NASF performed actions to implement the Local Health Council. The greatest national chances were for professionals graduated in public institutions (OR 2.2, 95% CI 1.2 - 4.0), who reported being trained by the management (OR 2.0, 95% CI 1.1 - 3.9); who carried out a health project in the country (OR 3.8, 95% CI 2.0 - 7.2); and those in the southern region of Brazil that had adequate physical structure for the practice of the profession (OR 0.1, 95% CI 0.0 - 0.9).

Keywords: social participation, unified health system, primary health care, family health support units.

Fatores associados a prática do controle social por profissional de educação física na atenção básica: levantamento nacional

RESUMO. O objetivo do estudo foi analisar os fatores associados à prática do Controle Social dos profissionais de educação física inseridos no Núcleo de Apoio à Saúde da Família (NASF) no Brasil. Estudo de abrangência nacional, exploratório, descritivo e de abordagem quantitativa realizado em 2011 com 296 profissionais de educação física das equipes do NASF. O desfecho do estudo foi o controle social. A razão de *Odds* foi estimada para verificar os fatores associados. Um terço dos profissionais de educação física inseridos no NASF realizou ações para implementação do Conselho Local de Saúde. As maiores chances em âmbito nacional foram para profissionais graduados em instituições públicas (OR 2.2; IC95% 1.2 - 4.0), que relataram ser capacitados pela gestão (OR 2.0; IC95% 1.1 - 3.9); que realizaram projeto de saúde no território (OR 3.8; IC95% 2.0 - 7.2); e aqueles da região Sul que possuíam estrutura física adequada para o exercício da profissão (OR 0.1; IC95% 0.0 - 0.9).

Palavras-chave: participação social, sistema único de saúde, atenção primária em saúde, núcleo de apoio à saúde da família.

Introduction

The Unified Health System (SUS), legitimized by the Brazilian Federal Constitution of 1988 is the current health model conceived in the logic of a public system that establishes the universal and equal access to services, taking health as a right for all and duty of the state (Brazil, 1988). In line with the principles of the Declaration of Alma-Ata, this model is based on the Primary Health Care (APS) (Brazil, 2002). The primary health care provides a set of systematic actions of a team to a family in a defined territorial area where the user makes his first contact with the health care network (Starfield, 2002).

In this context, the Ministry of Health (MS) created in 1994, the Family Health Strategy (ESF) and over the years, it added to the basic team the matrix support (AM) to further enhance and qualify the APS. Thus, in 2005, the Integral Assistance Nuclei in Family Health (NAISF) emerged, (Brazil, 2005), which in 2008 had its ordinance adjusted for the inclusion of new areas and new guidelines for the work organization, being then called Family Health Support Centers (NASF) (Brazil, 2008).

It is noteworthy that the NASF team is not a system gateway, since it plays the role of supporting ESF in the planning, implementation and evaluation

of health promotion, prevention and health care of the population (Brazil, 2008). The NASF professionals have general and specific duties related to the theoretical and methodological foundations of AM, which reinforce, from a horizontal organizational matrix, the importance of comprehensiveness, transdisciplinarity and overcoming of the health care model focused on illness and on the process of fragmented work (Campos & Domitti, 2007).

Social control is one of the fundamental pillars of SUS and AM, which aims to create link relations between user and ESF, contributing to the effective participation in the coordination of health care of people of that territory. Health councils and conferences are the main spaces of participation and social control, a mechanism of regulated and institutionalized participation. Through this, the population participates autonomously in public management and policies in each sphere of government (Brasil, 2011).

In 25 years of implementation of Social Control devices in health, 5,597 units of municipal, state and district health councils in Brazil (Brazil, 2015) are estimated. The influence of the health professional in the Social Control practice can be visualized in the worker's articulation with community through activities to encourage the formation of the Local Health Council (CLS) and educational or informational activities with local Health Counselors.

In literature, studies have pointed to the relevance of the teaching-service integration in the approach to social health management and control during initial training in all health professions (Bravo & Correia, 2012; Ceccim & Feuerwerker, 2004; Guizardi, 2015); however, there are few debates or research results about the performance of Physical Education professionals and Social Control practice (Loch, 2015; Luz, 2007). Considering the recent and ascendant history of this profession in the health field, especially in APS, the present study sought to analyze the factors associated with Social Control practice performed by NASF Physical Education professionals. This research proposes to help in the understanding of Social Control practices, considering the particularities of each region regarding the factors associated to the good performance of this social practice.

Material and methods

This is a nationwide, exploratory, descriptive and quantitative study carried out in 2011. Data were derived from research "Implementation of Family

Health Support Centers and Integration of the Physical Education Professional", approved by the Ethics Committee for Research with Human Beings of the Federal University of Santa Catarina (Protocol No. 197/2010). The research received authorization from the General Coordination of NASF, Ministry of Health and municipal management, where data collection was performed.

The target population was composed of Physical Education professionals working in NASF teams. According to the National Registration System of Health Facilities (SCNES), up to January 2011, 738 professionals were registered. Sample size was calculated in accordance with calculation described by Luiz and Magnanini (2000) for finite populations. The confidence level adopted was 95%, tolerable sampling error of five percentage points and relative frequency of 50%, obtaining a sample of 253 Physical Education professionals. For the control of confounding factors in association analyses, there was an addition of 20%, resulting in 303 professionals.

Physical education professionals were selected by stratified sampling method self-weighted for the different regions of the country and types of NASF. The selection occurred randomly from a list of names in alphabetical order. This information was extracted from data sent by the State Departments of Health and consultation with professional specialties registered in SCNES related to the category of Physical Education professionals (Brazil, 2008).

Professionals of temporary and permanent staff of the Municipal Health Department were included with time working in NASF of at least three months, aiming to minimize the effects of period of adaptation and integration with health teams. Professionals who during the data collection period were inactive, away from work or available to other organs and those on leave for different reasons or vacation were excluded.

Information was collected from July to September 2011 through a telephone interview, using a structured script validated as to content by a panel of experts and subsequently submitted to validation for clarity, applicability and reproducibility by NASF Physical Education professionals. A total of 46 subjects were randomly selected, proportional to each region of Brazil to participate in the reproducibility by application of the interview in two distinct moments in the interval of seven days. The concordance coefficient presented satisfactory results (Kappa coefficient = 0.62).

The interviewing team consisted of undergraduate and graduate students from the Federal University of Santa Catarina, with approximately 15 volunteers who received a theoretical and practical training lasting four

hours for the application of data collection procedures and during the process were supervised by responsible researchers.

Contact with the Physical Education professional of NASF was made through the Municipal Health Department or the body responsible for the NASF coordinating and only after consent, contact with professionals was made via phone and interview was scheduled according to their availability. The date of the interview could be scheduled for up to two weeks after the invitation to participate. At the time of interview, the professional was informed about the research and asked to read the Informed Consent Form. After verbal confirmation of acceptance, information was collected by the interview script, thus preserving the ethical precepts of the research. The maximum contact attempts with each professional were 10 times and the interview could be rescheduled five times.

The study's outcome variables are related to social control component assessed from community involvement in the planning of NASF actions and assistance in the training / implementation of CLS. The presence of social control actions was defined by the positive response to at least one of the following questions: I) Have activities to promote the training of CLS been carried out? II) Has NASF held educational and informational activities with the Local Health Counselors? To understand the Social Control practices carried out, information on the types of activities and issues addressed by Physical Education professionals with CLS were also recorded.

The association of "social control" outcome was tested with exploratory variables related to sociodemographic characteristics (gender and age group), academic training (education, specialization in Physical Education and health, type of higher education institution, type of graduation) and work environment (type of NASF; early action along with the implementation of NASF; employment; action in other service; weekly working hours; pedagogical training by the management, adequate material resources, adequate physical structure; evaluation of NASF actions together with CLS; evaluation of NASF actions by the management). Analyses were applied by analyzing the general context of Brazil and according to regions (Northern, Northeastern, Southeastern, Southern and Midwestern).

For increased reliability of data, double entry was held by two evaluators. Crossing of information was carried out in EpiInfo software, version 3.5.2, with correction for data that showed divergence after consulting the original source of information. Statistical analysis of data was performed using the SPSS software, version 15.0. Descriptive statistics (absolute and relative frequencies, mean, standard deviation and 95% confidence interval) was also

performed. To test the association between social control and exploratory variables, Chi-square and Fisher's exact tests were applied.

The association between social control in general and by regions of Brazil was tested by binary logistic regression, estimating the odds ratio (OR) and respective confidence intervals. In adjusted analyses, the following levels were considered: level 1, sociodemographic variables and professional training; and level 2, variables related to the work environment. The method used for the selection of variables was the backward and variables presenting p-values <0.20 in the Wald test at level 1 were used as adjustment of variables in the next level, and those of level 2 presenting the same critical value the Wald test in the final model. The significance level for all analyses was 5%. To observe the consistency of adjusted analyses, the Hosmer-Lemeshow goodness-of-fit test was used, and the cutoff point acceptable to confirm the model's discrimination quality was p value ≥ 0.79 (Hosmer & Lemeshow, 2000).

Results and discussion

A total of 296 physical education professionals were interviewed (response rate: 97.7%). There were three refusals, one from the northern and two from the northeastern regions, and four professionals selected for interview did not meet the inclusion criteria, two from the northeastern and two from Midwestern regions. There was no replacement due to the lack of eligible sample of professionals and the same type of NASF to replace the participant selected in the sample.

The majority of interviewed professionals were male, with mean age 32.3 years (SD = 7.4), graduated in private institutions, in courses for teachers formation and had a maximum degree in professional specialization. As for the work process in NASF, the highest proportions were of professionals accredited as NASF 1, included in the team since the implementation of the strategy, weekly workload of 40 hours, precarious employment relationship and, therefore, most worked in other services in addition to NASF (Table 1).

Among regions, there was a predominance of physical education professionals graduated in public institutions from the Northeast region, with the highest undergraduate degree in the Northern region, with stable employment in the Southern region and exclusive dedication to NASF also observed in the Midwestern region. In general, professionals positively reported the training and evaluation activities carried out by the NASF management; material resources and physical infrastructure available for work; besides the involvement of NASF team in evaluation activities of their practices with CLS and community engagement

for development of health projects in the territory (Table 1).

Social participation has difficulties in being fulfilled, because since implantation, it has faced a process of permanent construction. Its materialization depends primarily on the broad mobilization of the community by the defense of its rights. One of the main factors contributing to this scenario is the lack of information and the existence of multiple interests of omission of social rights by the population, so that they cannot demand them (Rolim, Cruz, & Sampaio, 2013). In

Physical Education, despite the increasing recognition of the profession in the engagement of social movements in health, the participation in these spaces still does not occur organically and effectively (Loch, 2015). In this study, it was observed that the practice of Social Control activities carried out by NASF Physical Education professionals has involved positive mechanisms to encourage community participation, among them the PST construction and health assessment actions together with management and / or local health councils.

Table 1. Sample distribution according to independent variables in Brazil and regions. (Brazil 2011).

Variáveis	n	Brazil (n) %	N (n) %	NE (n) %	MW (n) %	SE (n) %	S (n) %
Gender	296						
Male		(158) 53.4	(9) 56.3	(84) 57.9	(8) 53.3	(41) 47.7	(16) 47.1
Female		(138) 46.6	(7) 43.8	(61) 42.1	(7) 46.7	(45) 52.3	(18) 52.9
Age Group	295						
20 - 29 years		(126) 42.7	(9) 56.3	(61) 42.4	(5) 33.3	(38) 44.2	(13) 38.2
30 - 39 years		(123) 41.7	(6) 37.5	(56) 38.9	(10) 66.7	(35) 40.7	(16) 47.1
40 years and older		(46) 15.6	(1) 6.3	(27) 18.8	-	(13) 15.1	(5) 14.7
Scholarity	296						
Graduation		(131) 44.3	(11) 68.8	(63) 43.4	(4) 26.7	(42) 48.8	(11) 32.4
Specialization		(151) 51.0	(5) 31.3	(76) 52.4	(11) 73.3	(43) 50.0	(16) 47.1
Post-Graduation		(14) 4.7	-	(6) 4.1	-	(1) 1.2	(7) 20.6
Post-Graduation in PEH	152						
Yes		(106) 69.7	(4) 100.0	(52) 71.2	(8) 72.7	(28) 63.6	(18) 90.0
No		(46) 30.3	-	(21) 28.8	(3) 27.3	(16) 36.4	(2) 10.0
Type of HEI	296						
Public		(133) 44.9	(9) 56.3	(89) 61.4	(4) 26.7	(16) 18.6	(15) 44.1
Private		(163) 55.1	(7) 43.8	(56) 38.6	(11) 73.3	(70) 81.4	(19) 55.9
Type of graduation	295						
Full Degree		(221) 74.9	(13) 81.3	(107) 74.3	(13) 86.7	(61) 70.9	(27) 79.4
Teacher training		(27) 9.2	(2) 12.5	(17) 11.8	(2) 13.3	(4) 4.7	(2) 5.6
Bachelor		(47) 15.9	(1) 6.3	(20) 13.9	-	(21) 24.4	(5) 14.7
Type of NASF	296						
NASF 1		(238) 80.4	(10) 62.5	(119) 82.1	(9) 60.0	(73) 84.9	(27) 79.4
NASF 2		(42) 14.2	(5) 31.3	(20) 13.8	(6) 40.0	(7) 8.1	(4) 11.8
NASF Inter-municipal Consortium		(16) 5.4	(1) 6.3	(6) 4.1	-	(6) 7.0	(3) 8.8
Beginning of NASF operation	295						
From implantation		(247) 83.7	(14) 87.5	(124) 85.5	(13) 86.7	(68) 80.0	(28) 82.4
After implantation		(48) 16.3	(2) 12.5	(21) 14.5	(2) 13.3	(17) 20.0	(6) 17.6
Employment link	296						
Has link		(70) 23.6	(1) 6.3	(24) 16.6	(5) 33.3	(21) 24.4	(19) 55.9
Has no link		(226) 76.4	(15) 93.8	(121) 83.4	(10) 66.7	(65) 75.6	(15) 44.1
Linked to another service	296						
Yes		(171) 57.8	(11) 68.8	(93) 64.1	(5) 33.3	(50) 58.1	(12) 35.3
No		(125) 42.2	(5) 31.3	(52) 35.9	(10) 66.7	(36) 41.9	(22) 64.7
Working hours	295						
> 40 hours per week		(34) 11.5	(3) 18.8	(19) 13.2	(15) 100.0	(11) 12.8	(1) 2.9
≤ 40 hours per week		(261) 88.5	(13) 81.3	(125) 86.8	-	(75) 87.2	(33) 97.1
Training by management	296						
Yes		(167) 56.4	(8) 50.0	(93) 64.1	(9) 60.0	(35) 40.7	(22) 64.7
No		(129) 43.6	(8) 50.0	(52) 35.9	(6) 40.0	(51) 59.3	(12) 35.3
Material resources	296						
Yes		(170) 57.4	(12) 75.0	(79) 54.5	(10) 66.7	(55) 64.0	(14) 41.2
No		(126) 42.6	(4) 25.0	(66) 45.5	(5) 33.3	(31) 36.0	(20) 58.8
Physical structure	296						
Yes		(192) 64.9	(14) 87.5	(95) 65.5	(10) 66.7	(54) 62.8	(19) 55.9
No		(104) 35.2	(2) 12.5	(50) 34.5	(5) 33.3	(32) 37.2	(15) 44.1
Evaluation with the LHC	291						
Yes		(68) 23.4	(4) 25.0	(39) 26.9	(3) 20.0	(18) 21.7	(4) 12.5
No		(223) 76.6	(12) 75.0	(106) 73.1	(12) 80.0	(65) 78.3	(28) 87.5
Evaluation by management	296						
Yes		(224) 75.7	(15) 93.8	(114) 78.6	(12) 80.0	(63) 73.3	(20) 58.8
No		(72) 24.3	(1) 6.3	(31) 21.4	(3) 20.0	(23) 26.7	(14) 41.2
Performance of the THP	296						
Yes		(129) 43.6	(8) 50.0	(56) 38.6	(11) 73.3	(37) 43.0	(17) 50.0
No		(167) 56.4	(8) 50.0	(89) 61.4	(4) 26.7	(49) 57.0	(17) 50.0

N: Northern; NE: Northeastern; CO: Mid-Western; SE: Southeastern; S: Southern; PEH: Physical Education and Health; HEI: Higher Education Institution; NASF: Family Health Support Unit; LHC: Local Health Council; THP: Territorial Health Project.

About CLS, one third of professionals reported the implementation of CLS in Family Health Units (USF), with emphasis on the southern region of the country. Professionals from the northeastern, southeastern and southern regions of Brazil reported educational actions with counselors (Table 2). With regard to the national scenario, even with advances in social policies, there is still a great historical social inequality. It could be said that in the global organizational conjuncture, there is no way in which the government could be neutral; that is, the expected political equality envisaged in the Social Control guidelines, without economic equity (Gramsci, 2002). The engagement of professionals with the community potentially contributes to the struggle for better living conditions through the exercise of citizenship, including the participation of civil society in the decision-making spaces on public policies.

In the gross analysis of the exploratory variables with Social Control (Table 3), professionals aged 30-39 years, who had completed graduate studies in public institutions, were trained and evaluated by the USF management, and who carried out the health project in the country (PST) showed association with Social Control.

The characteristics of the initial training of health professionals directly impact their ability to assure a performance in health services that manifests the social commitment to promote the sanitary autonomy of people under their care (Rocha & Centurião, 2007). Ceccim and Feuerwerker (2004) pointed out that vocational training must meet people's health needs, develop autonomy and promote the formation of care policies, especially health care, which in turn are not restricted to the prophylactic aspects of disease treatment. Government initiatives, such as Experiences and Internships in the Reality of the Unified Health System (Ver-SUS) aim to achieve the objective of improve the multi-professional practice during training through the teaching – servisse – management- social control integration in the health field (Brazil, 2006).

In relation to Brazilian regions, PST was associated with Social Control in professionals from the northeastern and southeastern regions. Professionals from the southern region who reported developing evaluation activities of NASF with local management presented greater chances of performing Social

Control, as well as professionals from the southeastern region, who reported participation in management training activities. For the northeastern region, association between age group and type of higher education institution of the professional with Social Control was observed.

In the adjusted analysis (Table 4), professionals graduated in public institutions were twice likely of performing Social Control regarding the national context and in the southeastern region, this chance was 26.9 times. Professionals who reported qualification and evaluation by the management, especially in the southeastern region, were 61.5 times more likely of performing Social Control. In addition, professionals who participated in PST were 3.8 times more likely of performing Social Control, those in the northeastern region were 6.9 more likely of performing Social Control and those in the southeaster region were 34.8 times more likely.

The association between factors related to the qualification of the work process of Physical NASF Education professionals and the performance of PST demonstrates that the use of diverse technological health tools can favor the horizontal discussion among managers, professionals and community. Historically, the very construction of Social Control involves the working class, but it is recognized that this class is in crisis regarding its forms of organization and struggles, deeply stressed today by neoliberalism (Abreu, 2002).

A nationwide study on social participation showed that less than 3% of 2,200 respondents participate in public policy councils, for example Health and Education Councils, among others (Vaz, 2013). The case study of Rio de Janeiro state councils and conferences (Guizardi, 2015) showed that the current framework of representativeness of health councils, specifically in Rio de Janeiro, is not directly articulated to active movements and entities of civil society. The plenary and meeting spaces have been taken for internal and bureaucratic matters of participation / organization of events and meetings of state and national scope. Sometimes the counselors' training alternative is pointed out as a solution to the problem of the lack of representativeness of Councils due to the traditional and hegemonic understanding associated with this practice (Guizardi, 2015).

Table 2. Social Control activities carried out by NASF Physical Education Professionals. (Brazil. 2011).

Variable	n	Brazil		N		NE		MW		SE		S	
		n	%	n	%	n	%	n	%	n	%	n	%
LHC implanted in theFHU	296												
Yes		93	31.4	6	37.5	38	26.2	1	6.7	30	34.9	18	52.9
No		203	68.6	10	62.5	107	73.8	14	93.3	56	65.1	16	47.1
Encouraging the formation of LHC	296												
Yes		52	17.6	4	25.0	23	15.9	2	13.3	14	16.3	9	26.5
No		244	82.4	12	75.0	122	84.1	13	86.7	72	83.7	25	73.5
Activities with Counselors	93												
Yes		40	43.0	1	16.7	17	48.6	1	33.3	12	40.0	9	47.4
No		53	57.0	5	83.3	18	51.4	2	66.7	18	60.0	10	52.6

N: Northern; NE: Northeastern; CO: Mid-Western; SE: Southeastern; S: Southern; LHC: Local Health Council; FHU: Family Health Unit.

Table 3. Gross association analysis between exploratory variables and Social Control practice of Physical Education professionals in Family Health Support Units, (Brazil, 2011).

Variable	Social Control					
	Brasil	N	NE	MW	SE	S
	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)
Level 1						
Gender						
Male	1	1	1	-	1	1
Female	1.0(0.6; 1.7)	0.8(0.1; 6.9)	1.0(0.4; 1.2)	-	2.7(0.9; 8.0)	0.6(0.1; 2.3)
Age Group						
20 - 29 years	2.5(0.8; 6.7)	-	7.7(1.0; 62.3)	2.3(0.1; 45.7)	1.0(0.2; 5.9)	2.5(0.2; 29.3)
30 - 39 years	2.8(1.0; 7.6)	-	7.9(1.0; 63.6)	-	2.2(0.4; 11.8)	3.1(0.3; 34.4)
40 years and older	1	-	1	1	1	1
Scholarity						
Graduation	1	1	1	-	1	1
Specialization	1.4(0.8; 2.4)	0.7(0.1; 8.6)	2.1(0.9; 5.3)	-	0.7(0.3; 2.1)	1.6(0.3; 8.4)
Post-Graduation	3.3(1.1; 10.5)	-	3.4(0.5; 21.9)	-	-	3.6(0.5; 26.3)
Post-Graduation in PEH						
Yes	1.1(0.5; 2.6)	-	-	-	-	-
No	1	-	-	-	-	-
Type of HEI						
Public	2.0(1.2; 3.5)	3.0(0.2; 37.7)	2.7(1.1; 7.2)	-	2.0(0.6; 6.7)	1.1(0.3; 4.6)
Private	1	1	1	-	1	1
Type of graduation						
Full Degree	1	1	1	1	1	-
Teacher training	1.4(0.6; 3.5)	3.3(0.2; 70.9)	1.6(0.5; 5.1)	12.0(0.4; 374; 8)	1.1(0.1; 11.6)	-
Bachelor	0.6(0.3; 1.4)	-	0.2(0.1; 1.6)	-	0.6(0.1; 2.2)	2.5(0.4; 18.0)
Level 2						
Type of NASF						
NASF 1	0.8(0.3; 2.7)	-	1.1(0.1; 10.2)	-	0.4(0.1; 2.6)	-
NASF 2	0.9(0.3; 3.6)	-	1.7(0.2; 17.9)	-	1.5(0.2; 14.4)	-
NASF IC	1	-	1	-	1	-
Beginning of NASF operation						
From implantation	1.5(0.7; 3.4)	0.3(0.0; 5.8)	1.5(0.4; 5.6)	-	1.3(0.3; 5.2)	3.8(0.4; 36.4)
After implantation	1	1	1	-	1	1
Employment link						
Has link	1.6(0.9; 3.0)	-	1.5(0.5; 4.2)	-	1.8(0.6; 5.5)	1.4(0.4; 5.9)
Has no link	1	-	1	-	1	1
Linked to another service						
Yes	1	1	1	-	1	1
No	0.9(0.5; 1.6)	3.0(0.3; 31.6)	0.7(0.3; 1.6)	-	1.1(0.4; 3.3)	0.8(0.2; 3.4)
Working hours						
> 40 hours per week	0.7(0.3; 1.9)	-	1.2(0.3; 3.7)	-	0.8(0.2; 4.2)	-
≤40 hours per week	1	-	1	-	1	-
Training by management						
Yes	2.4(1.3; 4.4)	4.2(0.3; 53.1)	1.5(0.6; 3.7)	-	7.8(2.3; 26.7)	0.8(0.2; 3.3)
No	1	1	1	-	1	1
Material resources						
Yes	0.9(0.5; 1.6)	-	0.7(0.3; 1.5)	0.4(0.0; 9.0)	0.9(0.3; 2.5)	2.3(0.6; 9.6)
No	1	-	1	1	1	1
Physical structure						
Yes	0.9(0.5; 1.6)	3.7(0.2; 77.6)	0.9(0.4; 2.1)	2.3(0.1; 45.7)	0.8(0.3; 2.4)	1.9(0.5; 7.7)
No	1	1	1	1	1	1
Evaluation with the LHC						
Yes	1.6(0.9; 3.0)	1.0(0.1; 13.6)	1.7(0.7; 4.1)	5.5(0.2; 129.0)	2.8(0.8; 9.0)	0.5(0.0; 5.6)
No	1	1	1	1	1	1
Evaluation by management						
Yes	2.7(1.2; 6.0)	-	1.8(0.6; 5.6)	-	3.6(0.8; 17.0)	7.3(1.3; 41.7)
No	1	-	1	-	1	1
Performance of the THP						
Yes	3.6(2.0; 6.5)	1.0(0.1; 9.6)	4.5(1.9; 11.0)	-	4.7(1.5; 15.0)	2.1(0.5; 8.8)
No	1	1	1	-	1	1

IC95%: Confidence Interval of 95%; OR: OddsRatio. N: Northern; NE: Northeastern; CO: Mid-Western; SE: Southeastern; S: Southern; PEH:Physical Education and Health; HEI: Higher Education Institution; NASF: Family Health Support Unit;IC: Inter-municipal consortium; LHC: Local Health Council; THP:Territorial Health Project; Values in italics: level 1 variables that were for the adjusted model; Values in bold: p-value > 0.05; -: effect measures and confidence intervals were not estimated due to the insufficient number of individuals in the category.

Despite the acknowledged relevance of the construction of these formative spaces, the constant threats by conservative and hierarchical actions that advance against the social right to health guaranteed by SUS impair the crucial debates about political and institutional changes that directly affect public health. The use of the "formation of popular

representations" becomes a strategy of depositing in this social group bureaucratic and administrative knowledge that does not necessarily favor the access to information on the current scenario of the essential policies for a decision-making or policy and fight for the preservation of constitutional rights (Guizardi, 2015).

Tabela 4. Adjusted association analysis between exploratory variables and Social Control practices of Physical Education professionals linked to the Family Health Support Unit. (Brazil. 2011).

Variable	SocialControl					
	Brazil*	N*	NE [§]	MW**	SE++	S ^{§§}
	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)	OR (IC95%)
<i>Level 1</i>						
Gender						
Male	1	1	1	-	1	1
Female	0.7(0.3; 1.5)	1.1(0.1; 13.2)	2.0(0.5; 7.5)	-	0.1(0.0; 0.7)	1.0(0.0; 31.0)
Age Group						
20 - 29 years	3.8(0.8; 18.3)	-	3.4(0.3; 35.1)	1.8(0.1; 49.7)	3.2(0.2; 52.8)	-
30 - 39 years	2.7(0.6; 13.3)	-	2.2(0.2; 23.2)	-	0.7(0.0; 10.0)	-
40 years and older	1	-	1	1	1	-
Scholarity						
Graduation	1	1	-	-	-	-
Specialization	1.3(0.3; 5.8)	0.4(0.0; 6.6)	-	-	-	-
Post-Graduation	-	-	-	-	-	-
Post-Graduation in PEH						
Yes	1.1(0.5; 2.6)	-	0.3(0.1; 1.1)	-	0.9(0.1; 6.2)	-
No	1	-	1	-	1	-
Type of HEI						
Public	2.2(1.2; 4.0)	3.1(0.1; 98.9)	3.7(0.8; 17.6)	-	25.9(1.3; 497.9)	1.0(0.1; 6.7)
Private	1	1	1	-	1	1
Type of graduation						
Full Degree	1	1	1	1	-	-
Teacher training	1.9(0.5; 7.3)	2.7(0.1; 84.5)	6.4(1.0; 41.8)	12.0(0.4; 374.8)	-	-
Bachelor	1.2(0.3; 4.4)	-	-	-	1.0(0.1; 12.4)	1.0(0.1; 9.2)
<i>Level 2</i>						
Type of NASF						
NASF 1	0.4(0.1; 1.5)	-	-	-	-	-
NASF 2	0.5(0.1; 2.1)	-	-	-	0.9(0.0; 47.1)	-
NASF IC	1	-	-	-	1	-
Beginning of NASF operation						
From implantation	1.1(0.4; 2.9)	0.3(0.0; 41.9)	1.0(0.1; 8.4)	-	4.5(0.2; 125.8)	4.8(0.2; 111.9)
After implantation	1	1	1	-	1	1
Employment link						
Has link	1.8(0.9; 3.5)	-	1.2(0.2; 7.0)	-	0.1(0.0; 2.8)	0.6(0.1; 5.0)
Has no link	1	-	1	-	1	1
Linked to another service						
Yes	1	1	1	-	1	1
No	0.9(0.5; 1.7)	4.7(0.3; 72.2)	1.0(0.2; 6.1)	-	0.8(0.1; 11.0)	0.9(0.1; 9.9)
Working hours						
> 40 hours per week	0.8(0.3; 2.4)	-	2.9 (0.6; 15.0)	-	7.1(0.0; 2825.9)	-
≤40 hours per week	1	-	1	-	1	-
Training by management						
Yes	2.0(1.1; 3.9)	4.2(0.3; 53.1)	1.1(0.2; 5.5)	-	61.5(3.8; 998.6)	1.0(0.1; 16.3)
No	1	1	1	-	1	1
Material resources						
Yes	0.9(0.4; 1.8)	-	0.5(0.1; 1.9)	-	0.1(0.0; 1.4)	8.3(0.7; 94.2)
No	1	-	1	-	1	1
Physical structure						
Yes	0.7(0.4; 1.5)	-	1.2(0.2; 5.9)	-	0.1(0.0; 1.8)	0.1(0.0; 0.9)
No	1	-	1	-	1	1
Evaluation with the LHC						
Yes	1.4(0.7; 2.8)	0.4(0.0; 8.2)	0.8(0.2; 3.5)	5.5(0.2; 129.0)	4.6(0.2; 96.2)	0.3(0.0; 4.3)
No	1	1	1	1	1	1
Evaluation by management						
Yes	2.7(1.1; 6.4)	-	1.9(0.3; 10.1)	-	9.7(0.9; 110.8)	11.4(1.3; 99.6)
No	1	-	1	-	1	1
Performance of the THP						
Yes	3.8(2.0; 7.2)	-	6.9(1.8; 26.3)	-	34.8(3.4; 353.0)	1.4(0.2; 12.3)
No	1	-	1	-	1	1

IC95%: Confidence Interval of 95%; OR: OddsRatio. N: Northern; NE: Northeastern; CO: Mid-Western; SE: Southeastern; S: Southern; PEH:Physical Education and Health; HEI: Higher Education Institution; NASF: Family Health Support Unit; IC: Inter-municipal consortium; LHC: Local Health Council; THP:Territorial Health Project; * Adjusted in the final model with p value <0.20: type of HEI in level 1 and training by management, evaluation by management and performance of PSE in level 2. Hosmer-Lemeshow test p: 0.961; + no variable remained fit to the final model; § Adjusted in the final model with p value <0.20: specialization in Physical Education and Health, type of HEI in level 1 and performance of PSE in level 2. Hosmer-Lemeshow test p: 0.818; ** no variables remained in the final model; ++ Adjusted in the final model with p value <0.20: type of HEI at level 1 and qualification by management, material resources, management evaluation and achievement of PSE at level 2. Hosmer-Lemeshow test p: 0.931; § Adjusted in the final model with p value <0.20: material resources, physical structure and management evaluation at level 2. Hosmer-Lemeshow test p: 0.699; Values in bold: p-value> 0.05; -: effect measures and confidence intervals were not estimated due to the insufficient number of individuals in the category.

In reference to the main threats to public health, there is a sinuous presence of private interests in the health sector, thus demanding the challenge of social struggles in health for the search for a new

hegemony. Reaffirming the public and state character of health requires the sum of forces, health workers, local councils and organized civil society. The National Front against health privatization is

one of these spaces of democratic control in defense of SUS and quality of services offered, emphasizing that it does not replace the role of the health council, but adds the strength for the preservation of SUS (Bravo & Correia, 2012).

Another latent aspect nowadays refers to the recent engagement of the Brazilian population in social movements to broaden public spaces, that is, to go out on the streets expressing their interests and dissatisfaction indicates that society has made progress in claiming its rights. However, Matos, and Ferreira (2015) highlight the debate on the visibility and use of virtual spaces as a mechanism of protest and manifestation. The author also highlights the presence of an ambiguous visibility, which on the one hand favors the socialization of politics, and on the other, seeks to assert their own interests or the political society, using the power of force.

The use of information as a mechanism of force and massification can be counterbalanced by the qualification and "publicity" of tools that favor dialogue between institutions and society, allowing it to participate in the creation, execution, surveillance and control of actions, programs and governmental projects (Coutinho & Alves, 2015). The Law on Access to Information No. 12.527 / 2011 (Brazil, 2011) can be signaled as a potentiating element of transparency of public information produced and managed by the government and Social Control of public policies critically in relation to the three powers.

Interestingly, lower chances of performing Social Control were observed in the southeastern region by female Physical Education professionals and professionals from the southern region who had adequate physical structure to exercise their profession (Table 4). A theoretical explanation for such an outcome may be related to the good apparatus for Physical Education performance in the specific activities of the category, which sometimes unbalance the engagement of these professionals in joint actions with Family Health teams and the community. Research carried out in a municipality of Paraná indicates that the interviewed Physical Education professionals mentioned little about community mobilization strategies when reporting their activities in NASF (Souza & Loch, 2011).

The results identified in this study pointed to relevant aspects of the work process of NASF Physical Education professionals that directly or indirectly contribute to the implementation of CLS and reinforces the need for local health management to offer subsidies for social practices to be effective,

by encouraging, monitoring and evaluating the actions carried out at municipal level, being possible to extrapolate this commitment to other spheres of the government.

Some limitations may be pointed out in this study regarding the way the telephone interview was applied, as well as the impossibility of on-site observation of how Social Control activities are developed. On the other hand, the selection of this data collection procedure allowed a greater national comprehensiveness and representativeness of the research.

Conclusion

One third of professionals from all regions reported the implementation of CLS in USF. The characteristics that were most associated with the performance of Social Control by NASF Physical Education professionals were professionals graduated in public institutions, those who performed the evaluation and training by the management and PST. For professionals from the Northeastern region, the most associated characteristic was the performed of PST and from the Southeastern region, those graduated in public institutions, trained by the management and those who performed the PST, and for professionals from the Southern region, those who were evaluated by the management.

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