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Factors PHYSICAL EDUCATION PROFESSIONALS AT PRIMARY CARE AND SOCIAL CONTROL PRACTICES: NATIONAL SURVEY

SANTOS, S.F.S1, BENEDETTI, T.R.B2, GISELI MINATTO2, BORGES, R.A2, SOUSA, T.F3, SILVIO APARECIDO FONSECA, S.A4

Federal University of Amazonas/UFAM. Parintins – AM, Brasil1. Federal University of Santa Catarina/UFSC. Florianópolis – SC, Brasil2. Federal University of Triângulo Mineiro/UFTM. Uberaba – MG3, Brasil. Estadual University of Santa Cruz/UESC. Ilhéus – BA, Brasil4

ABSTRACT

To investigate the association between Social Control and sociodemographic characteristics, academic training and work environment. 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. In Brazil, Physical Education professionals graduated in public institutions were twice likely to perform Social Control. Regarding regions, professionals from the Southeastern region were more likely to perform Social Control, who reported being trained by the management; professionals from the southeastern and northeastern regions, who performed health project in the territory; and those from the southern region, who had adequate physical structure for the profession.

Keywords: Unified Health System, Primary health care, Physical education.

***Correspondence to Author:**
SILVIO APARECIDO FONSECA, S.A, Estadual University of Santa Cruz/UESC. Ilhéus – BA, Brasil.
email: sueylaf.silva @gmail.com

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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[1]. In line with the principles of the Declaration of Alma-Ata, this model is based on the Primary Health Care (APS)[2]. 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[3].

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[4], 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)[5].

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[5]. 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[6].

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[7].

About 5,597 units of municipal, state and health district councils are estimated in Brazil in 25 years of implementation of health social control devices[8]. The influence of the health professional's practice on social control can be viewed by the interaction between worker and community through activities to encourage the creation of the Local Health Council (CLS) and educational and informative activities with Local Health Counselors.

In NASF, the Physical Education Professional must, together with other professionals, always seek community involvement in the planning of NASF actions, thus achieving the essence of social control. In this sense, the aim of the study was to investigate the association between social control actions and sociodemographic characteristics, of academic training and work environment of physical education professionals working at NASF. Such investigation helps understanding Social Control practices, considering the particularities of each region and the factors associated with good performance of this social practice

METHOD

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[9] 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 as-

sociation 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[10].

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.

Data collection occurred from July to September 2011 through a telephone interview, using a structured and validated script regarding content, clarity and reproducibility[11]. The team of interviewers, about 15 volunteers, received theoretical and practical training lasting four hours for implementation of data collection procedures, and during the process, they had been 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[12].

RESULTS

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.

Most professionals interviewed were male aged 20-29 years, graduated in private institutions in Full Licentiate Degree, and had maximum degree of 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).

In the description of information about CLS, one third of professionals from all regions reported the implementation of CLS in the Family Health Unit (USF), with emphasis on the southern region of the country. The actions to encourage the formation of CLS were reported by approximately 25 % of professionals from the Northern and Southern regions. Professionals from the Northeastern, Southeastern and Southern regions reported conducting educational activities with counselors (Table 2).

In the crude analysis between explanatory variables and social control (Table 3), professionals in the age group 30-39 years enrolled in graduate programs, graduated in public institutions, who were trained and were evaluated by the USF management, who performed health project in the territory (PST) associated with social control performance. Regarding regions, PST performance was associated with social control in professionals from the Northeastern and Southeastern regions. Professionals from the southern region who reported developing evaluation of NASF activities with local management were associated with greater chances of social control performance, and professionals from the Southeastern region reported the participation in training activities by the NASF management. For the Northeastern region, association between age and type of higher education institution with social control was observed.

In the adjusted analysis (Table 4), professionals graduated in public institutions were twice as likely to carry out social control compared to the national context and 26.9 times more likely in the Southeastern region of Brazil. Professionals who reported training and evaluation by the management, particularly those from the Southeastern region, were 61.5 times more likely to carry out social control. Moreover, professionals who participated in PST were 3.8 more likely to carry out social control, those from the Northeastern region were 6.9 times more likely to carry out social control and those from to the Southeastern region were 34.8 times more likely to carry out social control.

It was observed that females and Physical Education professionals from the Southern region with adequate physical structure for the profession were less likely to carry out social control actions (Table 4).

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

Variables	n	Brazil	NO	NE	MW	SE	SO
		(n) %	(n) %	(n) %	(n) %	(n) %	(n) %
Sex	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 Groups	295						
20 at 29 years		(126) 42.7	(9) 56.3	(61) 42.4	(5) 33.3	(38) 44.2	(13) 38.2
30 at 39 years		(123) 41.7	(6) 37.5	(56) 38.9	(10) 66.7	(35) 40.7	(16) 47.1
40 yearsor more		(46) 15.6	(1) 6.3	(27) 18.8	-	(13) 15.1	(5) 14.7
Education	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
Postgraduate		(14) 4.7	-	(6) 4.1	-	(1) 1.2	(7) 20.6
SpecializationinPEH	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 de IHE	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
Typeofgraduation	295						
FullGraduatiom		(221) 74.9	(13) 81.3	(107) 74.3	(13) 86.7	(61) 70.9	(27) 79.4
Graduation		(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
ModeSNFH	296						
SNFH 1		(238) 80.4	(10) 62.5	(119) 82.1	(9) 60.0	(73) 84.9	(27) 79.4
SNFH 2		(42) 14.2	(5) 31.3	(20) 13.8	(6) 40.0	(7) 8.1	(4) 11.8
SNFHIC		(16) 5.4	(1) 6.3	(6) 4.1	-	(6) 7.0	(3) 8.8
Earlyaction in SNFH	295						
Sincethedeployment		(247) 83.7	(14) 87.5	(124) 85.5	(13) 86.7	(68) 80.0	(28) 82.4
Afterdeployment		(48) 16.3	(2) 12.5	(21) 14.5	(2) 13.3	(17) 20.0	(6) 17.6
Link Work	296						
Yes		(70) 23.6	(1) 6.3	(24) 16.6	(5) 33.3	(21) 24.4	(19) 55.9
No		(226) 76.4	(15) 93.8	(121) 83.4	(10) 66.7	(65) 75.6	(15) 44.1
Performance in other servisse	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
Workload	295						
> 40 hours weekly		(34) 11.5	(3) 18.8	(19) 13.2	(15) 100.0	(11) 12.8	(1) 2.9
≤ 40 hours weekly		(261) 88.5	(13) 81.3	(125) 86.8	-	(75) 87.2	(33) 97.1
Training for 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
Physicalstructure	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
EvaluationwhitLBH	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
Evaluationbymanagment	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
RealizationHPT	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

NO: North; NE: Northeast; MW: Midwest; SE: Southeast; SO: South;PEH: Physical Education Health; IHE: Institution of Higher Education; SNFH: Support Nucleus Family Health; IC: Intermunicipal Consortium; LBH: Local Board of Healt; PHT: Projet Health Territory

Table 2. Social control activities carried out by Physical Education professionals in Family Health Support Centers. Brazil. 2011.

Variables	n	Brazil		NO		NE		MW		SE		SO	
		N	%	n	%	n	%	n	%	n	%	n	%
LBHdeployed inHUF	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
Encourage the formation of LBH	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
ActivitiesAdvisors	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

NO: North; NE: Northeast; MW: Midwest; SE: Southeast; SO: South; LBH: Local Board of Health; HUF: Health Unit Family.

DISCUSSION

Social participation has faced difficulties to be achieved because since the implementation, it has undergone a process of permanent construction. Its materialization primarily depends on the wide community mobilization for the defense of their rights. One of the main factors contributing to this situation is the lack of information and the existence of multiple interests omission of social rights for the population, so that, they cannot assert them[13]. In Physical Education, despite the recognized advancement of the profession in the engagement of social movements for health, participation in these spaces still does not occur organically and effectively[14].

In this study, it was observed that the practice of social control activities performed by NASF Physical Education professionals has involved positive mechanisms for encouraging community participation, including the construction of PST and health evaluation activities in conjunction with the management and / or local health councils. With regard to the national scenario, even with advances in social policies, there is still a large and historic social inequality. It could be inferred that the global organizational context, the state cannot be neutral, i.e., the expected political equality provided in the social control guidelines without economic equity[15]. The engagement of professionals with 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 on public policies.

Initial training in public institutions and the *Lato-Sensu* postgraduate degree are among the factors associated with the practice of social control carried out by NASF Physical Education professionals. The characteristics of the initial training of health professionals directly affect their ability to play a role in health care that expresses the social commitment of promoting health for people under their care[16].

Cecim and Feuerwerker[17] pointed out that professional training should meet the health needs of people, develop autonomy and empowerment for the formation of health care policies, which in turn, are not restricted to 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 this goal of multidisciplinary practice during training by means of integrating teaching, service, management and social control in the health field[18].

Physical Education professionals who reported the development of training activities, evaluation of NASF activities by local management and the performance of PST were more likely to perform social control activities. The use of technological work tools in health among NASF Physical Education professionals favor the horizontal discussion among managers, professionals and community. Historically, the construction of social control involves the working class; however, it is recognized that this class is in crisis as for its forms of organization and struggle, deeply stressed today by neoliberalism[19].

The case study on councils and state conferences of Rio de Janeiro[20], showed that the current framework of representation of health councils, specifically in Rio de Janeiro, are not directly articulated to movements and organizations in civil society. The spaces of plenary and meetings have been taken by internal and bureaucratic issues of participation / organization of events and meetings in state and national spheres. Sometimes the alternative for counselor training is seen as a solution to the problem of low representation of councils due to the traditional and hegemonic understanding associated with this practice[20].

Despite the recognized importance of building these formative spaces, the constant threats by conservative and hierarchical actions that advance against the social right to health guaranteed by SUS causes the crucial debates on policies and institutional changes that directly affect health public to remain in the background. The “formation of popular representations” is then used as a strategy to deposit in these social groups bureaucratic and administrative skills that do not necessarily favor the access to information about the current scenario of the essential policies for decision-making or policy and struggle for preservation of constitutional rights[20].

Regarding the major threats to public health, unfortunately there is the presence of private interests in the health sector, thus requiring the challenge of social struggles in the search for a

Table 3. Crude association analysis between explanatory variables and the practice of social control actions of Physical Education professionals in Family Health Support Centers. Brazil. 2011.

Variables	Social Control					
	Brazil*	NO+	NE§	MW**	SE++	SO§§
	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)
1° Level						
Sex						
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 Groups						
20 at 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 at 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 yearsor more	1	-	1	1	1	1
Education						
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)
Postgraduate	**3.3(1.1; 10.5)**	-	3.4(0.5; 21.9)	-	-	3.6(0.5; 26.3)
SpecializationinPEH						
Yes	1.1(0.5; 2.6)	-	-	-	-	-
No	1	-	-	-	-	-
Type de IHE						
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
Typeofgraduation						
FullGraduatiom	1	1	1	1	1	-

Table 4. Adjusted association analysis between explanatory variables and the practice of social control actions by Physical Education professionals in Family Health Support Centers. Brazil. 2011.

Variables	Social Control					
	Brazil*	NO+	NE§	MW**	SE++	SO§§
	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)	OR (CI95%)
1° Level						
Sex						
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 Groups						
20 at 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 at 39 years	2.7(0.6; 13.3)	-	2.2(0.2; 23.2)	-	0.7(0.0; 10.0)	-
40 yearsor more	1	-	1	1	1	-
Education						
Graduation	1	1	-	-	-	-
Specialization	1.3(0.3; 5.8)	0.4(0.0; 6.6)	-	-	-	-
Postgraduate	-	-	-	-	-	-
SpecializationinPEH						
Yes	1.1(0.5; 2.6)	-	0.3(0.1; 1.1)	-	0.9(0.1; 6.2)	-
No	1	-	1	-	1	-
Type de IHE						
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
Typeofgraduation						
FullGraduatiom	1	1	1	1	-	-
Graduation	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)
2° Level						
ModeSNFH						
SNFH 1	0.4(0.1; 1.5)	-	-	-	-	-
SNFH 2	0.5(0.1; 2.1)	-	-	-	0.9(0.0; 47.1)	-
SNFHIC	1	-	-	-	1	-
Earlyaction in SNFH						
Sincethedeployment	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)
Afterdeployment	1	1	1	-	1	1
Link Work						
Yes	1.8(0.9; 3.5)	-	1.2(0.2; 7.0)	-	0.1(0.0; 2.8)	0.6(0.1; 5.0)
No	1	-	1	-	1	1
Performance in other servisse						

new hegemony in health. The reaffirmation of the public and state character of health requires the aggregation of forces, health workers, local councils and civil society organizations. The National Front against health privatization is one of the democratic controls of spaces in defense of the SUS and the quality of services offered, pointing out that it does not replace the role of the health council, but adds strength by the struggle to preserve the SUS[21].

Another latent aspect today refers to the recent engagement of the Brazilian population in social movements to extend the public space, that is, going to the streets expressing their concerns and dissatisfactions indicates that society has progressed in claiming its rights. However, Matos and Ferreira[22] highlights the debate on the visibility and use of virtual spaces as a protest and manifestation mechanism. The author highlights the presence of an ambiguous visibility that on the one hand favors the socialization of politics, on the other uses its own interests or political society, using the force of power[22].

The use of information as power and mass mechanism can be offset with the qualification and publicity of tools that promote dialogue between institutions and society, allowing it to participate in the creation, implementation, supervision and control of actions, government programs and projects[23]. The Access to Information Law No. 12.527/2011[24], can be seen as an enhancer element of transparency of public information produced and managed by the state and of social control of public policies critically in relation to the three powers.

Interestingly, lower chance to perform social control was observed among Physical Education professionals from the southern region that had adequate physical structure for the profession. A theoretical explanation for this result may be related to good apparatus for the performance of physical education in specific activities, which sometimes unbalances the engagement of this professional in joint actions with the family health teams and the community. Research conducted in the municipality of Paraná indicates that Physical Education professionals mentioned little about community mobilization strategies when report their activities in NASF[25].

The results presented in this study pointed to relevant aspects of the work process of NASF Physical Education professionals that directly or indirectly contributes to the implementation of CLS and reinforces the need for local health care management to provide subsidies for social practices to take effect, by encouraging, monitoring and evaluating the actions taken at the municipal level, which could be extrapolated to other levels of government.

Some limitations can be identified in this study such as form of application of the telephone interview, as well as the impossibility of *in loco* observation of how social control activities are developed. On the other hand, the choice for this data collection procedure allowed for a more comprehensive and nationally representative research.

CONCLUSIONS

The characteristics that were most associated with social control performance by NASF Physical Education professionals in Brazil were professionals graduated in public institutions, which carried out assessment and training by the management and PST. For professionals from the Northeastern region, it was the performance of PST. Regarding professionals from the Southeastern region, those graduated in public institutions, trained by the management and who performed the PST, and for professionals from the Southern region, the association with social control was higher for those who have been assessed by the management. Smaller associations were observed for professionals from the Southeastern region and for those who had adequate physical structure for the profession for the Southern region.

In the description of information about the CLS, one third of professionals from all regions reported the implementation of CLS, with emphasis on the southern region of the country. The actions to encourage the formation of CLS were reported by approximately 25 % of professionals from the Northern and Southern regions. Professionals from the Northeastern, Southeastern and Southern regions reported conducting educational activities with counselors.

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