

Social mobilization and citizen participation in health councils

Mobilização social e participação cidadã nos conselhos de saúde

Edna Moreira Barros¹, José Patrício Bispo-Júnior¹, Luzia Célia Batista Soares¹, Nívea Maria Silva Silveira¹, Berenice Temoteo-da-Silva², Mauro Serapioni^{1,3}

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ABSTRACT This study aimed to analyze social mobilization efforts and the role of representative entities in fostering participation in health councils across municipalities of different population sizes. It is a qualitative multiple-case study conducted in three municipalities in the state of Bahia, Brazil. Data were collected through document analysis and interviews with 30 health council members. A theoretical framework was developed based on the participation chain and decision-making domains models. Social mobilization was examined across three dimensions: micro, representing the individual perspective; meso, reflecting the role of community organizations; and macro, encompassing the dynamics of health councils. The results revealed low levels of community mobilization. At the individual level, limited interest in participation was observed. The meso dimension highlighted the weakening of traditional interest-based organizations, such as labor unions, alongside the growing prominence of recognition-based movements, such as the Black movement. The dynamics of the health councils demonstrated weak mobilization both internally and externally. The limited interest in community engagement was associated with an individualistic culture and a diminished sense of collective responsibility. The study concludes by underscoring the need to promote civic culture and strengthen community organizations.

KEYWORDS Health councils. Community participation. Social participation. Health policy. Unified Health System.

RESUMO Este estudo objetivou analisar as ações de mobilização social e a atuação das entidades representativas para a participação nos conselhos de saúde em municípios de diferentes portes populacionais. Constituiu-se em estudo qualitativo de casos múltiplos realizado em três municípios do estado da Bahia. Utilizaram-se como fontes de informação a análise de documentos e entrevistas com 30 conselheiros de saúde. Foi utilizada uma matriz teórica desenvolvida a partir dos modelos da cadeia da participação e domínios da tomada de decisão. Assim, a mobilização foi analisada nas dimensões: micro, perspectiva individual; meso, atuação das entidades comunitárias; e macro, dinâmica dos conselhos de saúde. Os resultados demonstraram frágeis níveis de mobilização comunitária. A dimensão individual identificou restrito interesse das pessoas pela participação. A dimensão meso evidenciou a fragilização das entidades tradicionais agregadoras de interesse, como os sindicatos, e um crescente protagonismo de entidades pautadas no reconhecimento, como o movimento negro. A dinâmica dos conselhos de saúde evidenciou diminutos níveis de mobilização nos contextos interno e externo. O limitado interesse para o envolvimento comunitário foi associado à cultura individualista e ao diminuto senso de responsabilidade coletiva. Conclui-se sobre a necessidade da promoção da cultura cívica e do fortalecimento das entidades comunitárias.

PALAVRAS-CHAVE Conselhos de saúde. Participação da comunidade. Participação social. Política de saúde. Sistema Único de Saúde.

¹ Universidade Federal da Bahia (UFBA), Instituto Multidisciplinar em Saúde (IMS) – Vitória da Conquista (BA), Brasil. jpatricio@ufba.br

² Universidade Federal da Bahia (UFBA), Instituto de Saúde Coletiva (ISC) – Salvador (BA), Brasil.

³ Universidade de Coimbra (UC), Centro de Estudos Sociais (CES) – Coimbra, Portugal.



Introduction

Social mobilization initiatives serve as strategies both to defend social rights and to ensure equitable access to – and continuity of – healthcare¹. Within health systems, community mobilization efforts are frequently employed to control endemic diseases², improve the health of specific population groups³, combat violence⁴, and promote vaccination⁵. While participatory actions aimed at addressing specific issues are undoubtedly valuable, the broader challenge of social mobilization lies in achieving lasting social and systemic improvements in community well-being⁶.

There is considerable debate in the literature about the concept and aims of social mobilization. Rogers, Goldstein, and Fox⁷ define it as the capacity to motivate individuals to engage in behaviors that primarily benefit a collective group. Fernandes et al.⁸ highlight that social mobilization occurs when a group of people, a community, or even a society decides to act together toward a common goal, striving daily to achieve outcomes that are collectively defined and desired. Diani⁹ conceives social mobilization as the voluntary organization of individuals, groups, or institutions working together to produce collective goods. Drawing on these perspectives, this article adopts the understanding of community mobilization as the engagement of individuals united by shared goals who act collaboratively to advance a common cause.

In the health literature, the concepts of mobilization and participation are often closely linked. Over the past decades, multiple meanings have been ascribed to the term social participation⁶. In this article, social participation is understood in relation to broader democratic ideals, and it is characterized as a process through which individuals and communities act to influence decisions concerning their health and the organization of both promotional and care services¹.

Engagement in social movements or collective initiatives is one of the main factors

that motivates people to participate¹⁰. In the debate surrounding traditional and new social movements^{11,12}, it is emphasized that traditional movements emerged primarily in the twentieth century, grounded in the defense of broader social policies, and characterized by stable and enduring structures. In contrast, the new social movements that have arisen in recent decades are defined by more fluid and temporary structures, their intersection with other social issues, their focus on identity-based agendas, and their emphasis on the importance of an intersectional approach in policymaking.

Even considering the diffuse nature of these movements¹², the literature points to a current scenario marked by the weakening of social mobilization and collective action^{10,13,14}. Miwa e Ventura¹⁵ argue that this demobilization is driven by an increased emphasis on individualization and consumer interests, which tend to overshadow collective values and the pursuit of the common good.

In Brazil, social mobilization efforts played a crucial role in the creation of the Unified Health System (SUS). According to Paim et al.¹⁶, the Brazilian Health Reform took a path contrary to the reforms that spread throughout much of the world in the final decades of the twentieth century. While other countries were questioning the sustainability of the welfare state, Brazil established the SUS on the principles of social solidarity, health as a right, and a broad conception of health. The authors¹⁶ emphasize that a key feature in the formation of the SUS was that the reform process was driven by civil society mobilization rather than by the government or international organizations.

As an important democratic innovation, social participation was institutionalized within the SUS through health conferences and councils¹⁷. These participatory mechanisms were established at the municipal, state, and federal levels, ensuring the representation of diverse social sectors and placing strong emphasis on community involvement.

Health conferences are held every four years to assess the health situation and propose guidelines for health policies. These forums are widely recognized as crucial spaces for strengthening the democratic process and fostering social participation within the SUS¹³. The role of health councils is to integrate features of institutional engagement with those of social mobilization¹⁷. While the role of health councils in advancing the democratization of the state and health policies is broadly acknowledged¹⁸, significant limitations in community involvement are also evident in these forums¹⁹. Although the conferences have great potential to mobilize the population in defense of the SUS²⁰, this study centers on the dynamics of social mobilization within health councils. Viewing these councils as permanent deliberative arenas, the study aimed to explore the mobilization processes that underpin the engagement of social representatives.

Given the institutional significance of health councils and, at the same time, the weakening of community participation within these spaces, there is a clear need to deepen analyses of the various dimensions that influence community mobilization and the engagement of individuals and organizations. This study aims to examine social mobilization initiatives and the role of representative entities in fostering participation in health councils across municipalities of different population sizes.

Material and methods

Study design

This is a qualitative study employing a multiple case approach with embedded levels of analysis²¹. The units of analysis included the health councils, as well as the activities of participants and representative entities that make up the health councils of three municipalities in the state of Bahia. Social mobilization was examined by considering the actions of social

representatives, representative institutions, and the health councils themselves.

Theoretical-methodological framework

The theoretical–methodological framework draws on the articulation of two theoretical models widely applied internationally in the analysis of social participation: the participation chain model²² and the decision-making domains model²³.

Simmons e Birchall²² developed the theoretical model of the participation chain to identify the factors that influence people's involvement in issues related to social policies. The model systematizes the main incentives, attitudes, and barriers that either facilitate or hinder citizen participation. The participation chain comprises four factors or links: mobilization, motivation, resources, and institutional dynamics. For this study, the dimension of social mobilization was adopted. According to the authors, engagement is shaped by factors that can either attract individuals to, or discourage them from, the process of social mobilization.

In their decision-making domains model, Charles and DeMaio²³ identify three levels that encompass the key dimensions of citizen involvement. For this study, the decision-making domain was adopted, comprising three dimensions: the individual level, the service level, and the macro-level decision-making context. Based on this framework, the levels of participation and mobilization were categorized as micro, meso, and macro.

At the micro level, the study explored factors that influence mobilization at the individual level—specifically, the elements that encourage or discourage people from engaging with health-related issues. The meso level examined mobilization through the lens of institutions that bring together community interests within each municipality. At this intermediate level, the focus was on how civil society organizations are structured

and mobilized in the different municipalities studied. Finally, the macro level corresponded to the municipal decision-making arena of the SUS—namely, the municipal health councils. This dimension focused on the participation and actions of social representatives within

the councils, as well as the forms of social mobilization promoted by these bodies.

A theoretical matrix was developed through the convergence and adaptation of the two models^{22,23}. The resulting matrix comprises three dimensions (*box 1*).

Box 1. Analytical matrix on social mobilization in health

Dimension	Subdimension
Participatory culture	Interest and willingness of individuals to engage in social participation
	Participatory tradition
Role of representative community organizations	Forms of organization and action of representative bodies
	Community mobilization practices of representative bodies
Institutional dynamics of health councils	Internal dynamics of health councils
	External dynamics of health councils

Source: Prepared by the authors, based on the principles of social mobilization in participatory spaces²²⁻²⁵

The development of the dimensions and subdimensions of the theoretical matrix incorporated elements from both the participation chain model²² and the decision-making domains model²³, as well as characteristics of participation²⁴ and mobilization²⁵ observed in Brazil's health councils. The subdomains were subsequently adapted to reflect the dynamics of participation within the SUS.

The first dimension, participatory culture, corresponds to the individual level and comprises two subdimensions: individuals' interest and willingness to engage in social participation, and the tradition of participatory practices. The second dimension, the performance of representative community organizations, pertains to the intermediate level and encompasses their organizational structures, activities, and mobilization practices. The third dimension, representing the macro level of the matrix, focuses on the institutional dynamics of health councils. It includes two subdimensions: internal dynamics, referring to community participation in meetings, the

agenda-setting capacity of social representatives, and their influence on council deliberations; and external dynamics, concerning the councils' ability to coordinate, mobilize, and recruit participants.

Study setting

The study was conducted in three municipalities of the state of Bahia with different population sizes: Urandi, Guanambi, and Vitória da Conquista. The selection aimed to include a small municipality (fewer than 25,000 inhabitants), a medium-sized municipality (between 25,000 and 100,000 inhabitants), and a large municipality (with more than 100,000 inhabitants)²⁶.

Urandi has a population of 15,355 inhabitants²⁷ and is part of the Guanambi Health Region²⁸. The Urandi Health Council, composed of 16 full members, operates within the premises of the municipal government. Although it lacks its own budget allocation, the council has access to a computer, printer,

and internet connection²⁹. Guanambi has a population of 87,817 inhabitants² and serves as the headquarters of the Health Region, which comprises 23 municipalities²⁸. The Guanambi Health Council is composed of 16 full members. Although it does not have its own headquarters, it has an executive secretariat, a computer, a printer, and an internet connection^{29,30}. Vitória da Conquista has a population of 370,879 inhabitants²⁷, making it the third most populous municipality in the state of Bahia. It serves as the headquarters of the Southwestern Macroregion, which comprises 74 municipalities²⁸. The Municipal Health Council (CMS) is composed of 24 full members, has its own headquarters and adequate infrastructure, and is equipped with an executive secretariat and transportation, although it does not have a specific budget allocation²⁹.

Sources of information and study participants

The study drew on information and data obtained through document analysis and semi-structured interviews. The documentary review covered the minutes of municipal health council meetings from 2019 to 2022, the internal regulations of the three councils, management reports, and municipal

decrees, ordinances, and laws related to social participation.

As shown in *table 1*, a total of 30 health council members were interviewed. Participants were intentionally selected to include representatives from all sectors of the councils. Between August and October 2022, ten members were interviewed in each municipality: four user representatives, two health professionals, two managers, and two service providers. The number of participants was defined a priori to ensure representation from all groups that make up the municipal health councils. Participants were selected based on their level of engagement in meetings, their ability to connect with others, and their involvement in mobilization activities, ensuring a diversity of participation profiles. Council members who had served for less than six months were excluded. The interviews lasted an average of 69 minutes, totaling 2,080 minutes of recorded material. The interview guide explored topics such as individuals' interest and willingness to engage in social participation; the organization, engagement, and mobilization practices of associations and unions; the dynamics of council meetings and their decision-making processes; and the social mobilization initiatives carried out by each council.

Table 1. Study participants by sector and municipality. Urandi, Guanambi, and Vitória da Conquista, 2023

Interviewees	Urandi	Guanambi	Vitória da Conquista
Municipal Health Council Members			
Service users	4	4	4
Healthcare professionals	2	2	2
Managers	2	2	2
Service providers	2	2	2
Total	10	10	10

Source: Prepared by the authors.

Data analysis

All interviews were transcribed and verified by the research team. Relevant excerpts from the documents were also incorporated into the analysis material. The data were organized, refined, and coded using the Thematic Content Analysis technique proposed by Gibbs³¹. The resulting categories were then examined according to the dimensions and subdimensions previously defined in the analytical matrix (box 1).

Ethical considerations

The study was authorized in advance by the three municipal health councils and approved by the Human Research Ethics Committee of the Multidisciplinary Health Institute, Anísio Teixeira Campus, Federal University of Bahia (CAAE No. 57675422.1.0000.5556, opinion No. 5.406.361). All researchers complied with the ethical requirements established in Resolution No. 466/2012³² of the Brazilian National Health Council.

Results

The findings revealed weak levels of community mobilization across the settings analyzed. In all three dimensions of the analytical matrix—micro, meso, and macro—there were consistent challenges in fostering mobilization around health advocacy and council activities. The weaknesses observed in these three dimensions appeared to be interrelated and mutually reinforcing, leading to a cycle of limited community engagement and the gradual weakening of representative organizations. The results are presented below according to each analytical dimension.

Participatory culture

At the micro level, which relates to individual aspects, both interest and willingness to engage

in participation were found to be limited. The low level of community involvement was associated with an individualistic culture and a weak sense of social responsibility.

People don't really have that concern for social mobilization, you know? We can't generalize, of course, but participation should be much broader and far more active than it actually is. [...] Nowadays, social awareness about these issues is minimal. (Interview 08, Vitória da Conquista – Service Provider).

A prevailing sense of disbelief in social participation and in the work of health councils was evident. The lack of trust in participatory processes appeared to undermine community efforts toward social mobilization. “*I see a lot of people who are kind of disillusioned, you know, or who just don't really want to take part in things*” (Interview 23, Urandi – User).

The population's sense of disbelief and lack of interest appeared to be influenced by the persistence of community health problems and the difficulties faced in accessing and maintaining continuity of care within health services. The analysis of health council meeting minutes from the three municipalities revealed ongoing complaints and demands from social representatives concerning the limitations of the care provided. This situation was also reflected in the participants' interviews, who explained that people tend to distance themselves from the health councils because their participation does not lead to tangible changes in health services. “*People see that they keep taking part, but things just don't happen, you know? And then they start to withdraw increasingly*” (Interview 04, Vitória da Conquista – Manager).

Regarding the subdimension of participatory tradition, there was evidence of a decline in people's interest and a weakening of social mobilization capacity. In all three settings analyzed, there had once been active community mobilization processes that gradually lost strength over the years.

Over time, people's interest in taking part has really declined. This affects not only participation in the council but also several government initiatives. (Interview 30, Urandi - Manage).

The tradition of participation also appeared to have been undermined by feelings of frustration and powerlessness associated with spaces for participation. When the health councils were first established, all three municipalities experienced social mobilization processes that sparked hope that citizens' needs and voices would be heard and addressed. However, over time, these mobilization efforts lost momentum, and people became increasingly disengaged from participation.

Role of representative community organizations

The study revealed a contradictory scenario at the intermediate level of community mobilization. It identified a process of social demobilization and the weakening of traditional interest-based organizations, such as labor unions and local associations. Although these entities still hold seats on the health councils examined, they have struggled to sustain consistent dialogue with their members and to maintain active mobilization efforts.

Very, very weak —almost no mobilization from the associations. [...] In general, health issues here in the municipality are rarely brought up or demanded. (Interview 21, Urandi - Health Professional).

At the same time, new representative organizations have emerged and taken a leading role—groups grounded in identity and recognition, such as associations of mothers of children with disabilities and the Black movement. These organizations have shown greater capacity for mobilization and participant engagement.

The mothers of children with autism have organized themselves and have been advocating for

better public policies for their children, you know? (Interview 04, Vitória da Conquista - Manager).

Women have started organizing to bring gender issues into the discussion. The Black movement is growing stronger, coming together through different groups, you know? The LGBTQIAP+ movement is also organizing as a collective voice in this process of advocacy and debate. [...] And so, other movements are organizing themselves, right? (Interview 02, Vitória da Conquista - User).

These organizations have begun to compete for representation within the health councils, particularly in the larger municipalities. Even when they do not hold a formal seat, their strong mobilization capacity allows them to exert influence in defending their interests. However, the study showed that the work of these identity-based organizations tends to focus mainly on advocating for specific benefits and policies for the groups they represent, rather than engaging in the defense of broader social interests.

What I see is that many associations are fighting for their own interests, not for the collective good—except maybe the community in that location. [...] So, what I see is that these organizations aren't united around a common cause; they're united around their own specific goals. (Interview 16, Guanambi - Manage).

In the subdimension concerning the mobilization practices of representative organizations, significant challenges were identified in carrying out activities related to community coordination, organization, and engagement. Labor unions and local associations have struggled to mobilize both community members and their own affiliates. The study revealed that people's lack of interest in participating negatively affects mobilization efforts at the meso level, leading to a state of inertia among organizations when it comes to promoting community mobilization initiatives.

We, from the rural union, used to have 100% support of the rural associations. [...] Today, we don't even reach 50% of them. Why? Because most people get caught up in politics, you know? 'Oh, if I go to the union, I don't get anything out of it'. (Interview 14, Guanambi - User).

Although identity-based organizations tend to have greater mobilization capacity, their activities differ in nature from those of traditional representative entities. Their mobilization efforts are mostly sporadic—often taking the form of protests or gatherings aimed at engaging people to attend meetings or events with local officials in support of a specific cause. These organizations also make extensive use of social media as a key strategy to mobilize members and raise public awareness about the issues they advocate for.

Institutional dynamics of health councils

The analysis of the institutional dynamics of health councils also revealed low levels of mobilization, both internally and externally. A review of the meeting minutes and attendance lists from the three councils showed that participation by non-members was limited. Greater public attendance tended to occur only when specific agenda items of interest to certain groups were being discussed. In general, however, ordinary citizens showed little interest in or engagement with the councils' activities.

But the general public is actually going to the council? No, they don't. Students only show up when a teacher assigns it as an activity. Other than that, no one seeks out the council. (Interview 13, Guanambi - Manager).

In all three cases analyzed, social representatives demonstrated a strong capacity to set the agenda. Participants from the user and health worker segments were able to propose topics for discussion within the councils. However, these representatives had limited influence

over final decisions. Although the councils' deliberative spaces appeared open to including issues of interest to social groups, the decision-making process itself was largely dominated by managerial representatives, who exerted greater control and influence over the other segments. *"Sometimes the managers don't want to listen. They just want to push through their own ready-made policies. But these policies need to be discussed with the people, right?" (Interview 03, Vitória da Conquista - User).*

In the subdimension concerning the councils' external dynamics, the study revealed weak coordination between the health councils and civil society organizations in promoting social mobilization and encouraging public engagement with the councils' activities. In Vitória da Conquista, a thematic committee on social mobilization was identified, established to publicize the councils' work and raise public awareness about participation. However, this committee's activities were limited, and its mobilizing capacity proved to be weak.

We have a mobilization committee within the council, but actual mobilization doesn't really happen. I'd say we're missing about 80% of it — mobilization is very low. (Interview 01, Vitória da Conquista - User).

Several initiatives were identified that aimed to generate greater public interest and engagement. Efforts to publicize and invite community members to attend meetings were made at different times. The analysis of the council minutes, corroborated by interview findings, also revealed proposals for holding itinerant meetings aimed at bringing health councils closer to local communities.

We set up meetings, announce them on the radio, even use loudspeaker cars [...] We ask the community to be there, to put on some pressure, right?! Maybe to stop a certain proposal or to get it approved, and still, very few people show up. (Interview 20, Guanambi - User).

The results showed that the mobilization and recruitment initiatives promoted by the councils were not only sporadic and fragmented but also largely ineffective. No consistent capacity for mobilization was identified. The actions discussed, and those actually implemented, proved to have limited appeal and a very modest ability to engage or mobilize the community.

Discussion

Social mobilization was examined at three levels: individual, referring to factors that influence people's engagement; meso, related to community representative organizations; and macro, corresponding to the municipal deliberative arenas—the health councils. Across all three dimensions, community involvement in health was found to be minimal, which appeared to weaken broader processes of social mobilization. The analysis revealed a context marked by citizens' disengagement from participatory practices and the fragility of representative organizations. These factors were also associated with the limited mobilizing capacity observed within the health councils.

Despite the leading role of social participation and civil society engagement in shaping the social foundations of Brazil's Unified Health System (SUS), maintaining high levels of social mobilization has proven difficult to achieve. Bispo Júnior and Serapioni²⁴ emphasize that social mobilization and community engagement remain major challenges to the effective functioning of health councils. They argue that sustaining high levels of mobilization has been difficult, and that the institutionalization of these councils alone has not been sufficient to keep civil society organized and active in defending the public health system.

In discussing citizens' apparent lack of interest in participatory spaces, Valla³³ warns of the need to move beyond the interpretive bias often held by academics and professionals. What might initially be seen as apathy

or indifference, he argues, is in fact a clear expression of the population's awareness of the limited potential for meaningful change within formal participatory arenas. Moreover, it is essential to consider the structural, social, and political factors that frequently constrain the expression of community demands and the influence of social representatives.

Regarding the participatory culture dimension, the results revealed a limited interest in civic engagement. Social mobilization was hindered by the fragility of participation at the individual level. A key factor negatively affecting people's willingness to participate was their disbelief in the power of collective action. This feeling of disillusionment is closely tied to the erosion of social belonging⁷. When individuals lose faith in the strength of collective efforts, they tend to withdraw and prioritize individual solutions. Accordingly, the authors argue that strengthening social bonds and a shared sense of identity can encourage behaviors oriented toward the common good.

Difficulties in accessing health services also contributed to weakening individuals' interest in participation. Throughout its more than 30 years of existence, the SUS has never had sufficient funding and continues to face structural problems that hinder access, continuity, and quality of healthcare². These shortcomings in health service delivery have fostered public disillusionment with the system and, consequently, reduced motivation for social mobilization.

In the meso-level analysis, concerning the role of representative community organizations, the results reveal a transitional scenario—both in the types of organizations taking the lead in mobilization processes and in their modes of operation. Traditional representative organizations within the councils, such as labor unions and neighborhood associations, have lost ground in these participatory spaces, while organizations structured around identity and recognition have gained prominence.

The new social movements are grounded in identity among equals, strengthened by

emotional bonds that consolidate internal unity in contrast to external or differing social expressions¹². These movements mobilize in defense of their members' rights and challenge the existing social order, yet they do not necessarily seek to bring about substantial changes in power structures¹². Within participatory health forums, Cohn¹⁹ warns of the risks inherent in fragmented participation driven by narrow, group-specific interests, which can hinder broader mobilization and advocacy for universal health rights. In the context of this study, although identity-based movements demonstrated greater mobilizing capacity, their actions were largely directed toward advancing the specific interests of the groups they represent.

Furthermore, the mode of action displayed characteristics that differ from those of classical social movements. The study identified a considerable capacity for mobilization around specific causes, often through the formation of pressure groups aimed at generating tension in particular contexts, but without a consistent or enduring institutional structure. According to Ricci¹², from the 1990s onward, social movements became increasingly fragmented, with a shift from stable organizational forms to more temporary and unpredictable modes of action. The author uses the term *swarming* to describe the provisional and fluid nature of mobilization.

The analysis of the macro dimension—the institutional dynamics of the health councils—revealed limited capacity for mobilization. Within the internal dynamics subdimension, the results indicated, as a positive aspect, the strong agenda-setting capacity of social representatives. However, it also became evident that these representatives had limited influence over the councils' final decisions.

The deliberative processes within the health councils are marked by significant power asymmetries. Several studies have shown that the representatives of the management segment play a strong inductive role in decision-making. In the municipalities of

Marabá²⁵, in the state of Pará, and Nova Canaã and Itapetinga²⁴, in Bahia, asymmetric deliberative processes were identified, with the municipal administration exerting predominant influence over decisions. These findings reinforce the challenges related to internal mobilization and the limited political influence of social representatives.

Regarding the external dynamics, the health councils were found to engage in only minimal social mobilization efforts. Their limited capacity for mobilization appears to be linked to a lack of connection between the councils and civil society. In many contexts, the councils are largely unknown to the population¹⁸ and maintain weak dialogue with other control bodies³⁵. It is plausible that this modest level of social mobilization within the councils contributes to the weak mobilization observed at both the intermediate and individual levels.

In this context, it is essential to consider the political, social, and health scenario in Brazil during the study period (2019–2022). Under the Temer and Bolsonaro administrations, the country underwent a period marked by severe fiscal austerity, dismantling of social policies, and systematic attacks on participatory institutions. During Bolsonaro's government, Brazilian democracy came under threat, and a clear effort was made to dismantle participatory governance structures. The repeated assaults on democratic institutions and on the SUS promoted by the Bolsonaro administration imposed obstacles to the functioning of health councils and discouraged social mobilization processes and the activities of representative organizations.

The COVID-19 pandemic also had a significant impact on civic participation. Preventive distancing measures led many health councils to suspend or scale back their activities³⁶. Moreover, during the most critical stages of the crisis, political leaders turned primarily to expert groups for advice, leaving participatory institutions on the sidelines. In practice, the creation of crisis committees pushed the councils' deliberative role into the background.

This sidelining of participatory spaces may have had lasting effects, contributing to broader and more enduring processes of social demobilization³⁶.

At the same time, it is worth considering how the pandemic gave rise to new actors in the public sphere and redefined how collective action takes shape. One notable example is the Frente pela Vida (Front for Life) movement, which emerged in response to the health crisis but soon evolved into a broader movement, mobilizing society around the idea that health must be integral to Brazil's development agenda³⁷. The FpV movement has established itself as a key social actor in recent years, challenging the state in defense of life and the right to health³⁸. Likewise, some free conferences emerged as a new mobilizing strategy and a means of bringing together diverse social interests. The Free, Democratic, and Popular National Health Conference, organized by the FpV in 2022, inspired this participatory model, which has since been widely adopted by social movements advocating for health. It is plausible that these new actors and forms of mobilization positively influenced participatory practices in the municipalities studied, particularly during the pandemic period

Final considerations

This study contributes to the literature by identifying factors that may strengthen social participation and enhance community mobilization in health. Through a three-level analytical framework, it was possible to pinpoint elements that influence social mobilization within the health sector. At the individual level, participation was found to be limited, largely due to widespread skepticism about the effectiveness of participatory mechanisms and community engagement efforts. At the intermediate level, organizations grounded in identity- or recognition-based causes

demonstrated greater mobilizing capacity than traditional representative bodies. However, their actions tended to focus on advancing the specific interests of their members rather than promoting broader public health agendas. Finally, at the macro level, health councils continue to display low levels of community participation and limited ability to foster engagement.

Strengthening social mobilization within the health sector remains an essential challenge. Building a stronger participatory culture depends on valuing participatory spaces and ensuring that citizens' voices and demands are genuinely reflected in decision-making processes. Promoting participation also entails empowering community organizations and supporting inclusive public policies that address both collective priorities and the specific needs of diverse groups. In doing so, it becomes possible to foster greater public trust and interest, encourage broader engagement in collective movements and participatory arenas, and ultimately broaden social mobilization in defense of the SUS.

Collaborators

Barros EM (0000-0001-9699-3825)* and Soares LCB (0000-0002-6992-4928)* contributed to data collection, analysis, and interpretation, manuscript drafting, and approval of the final version to be published. Bispo-Júnior JP (0000-0003-4155-9612)* and Serapioni M (0000-0002-5761-2660)* contributed to the study conception, data analysis and interpretation, manuscript drafting, and approval of the final version to be published. Silveira NMS (0000-0002-0180-054X)* and Temoteo-da-Silva B (0000-0003-0951-3489)* contributed to data analysis and interpretation, critical manuscript revision, and approval of the final version to be published. ■

*Orcid (Open Researcher and Contributor ID).

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