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Reducing unequal access to health promotion actions in Primary Care in Brazil: Health Academy Program

Redução da desigualdade de acesso às ações de promoção da saúde na Atenção Primária brasileira: Programa Academia da Saúde

Abstract

Introduction: The health situation outlined by a high prevalence of chronic non-communicable diseases reveals the need for restructuring health care. In this sense, services such as the Health Academy Program (herein PAS) were implemented in Brazilian Primary Health Care (PHC). ***Objective***: To analyze, from the perspective of users, PAS as an opportunity to reduce unequal access to health promotion actions in PHC. ***Method:*** This is a qualitative study carried out at the first PAS unit implemented in Belo Horizonte-MG, with participants who started using the service between 2007 and 2011. Data collection was carried out through semi-structured interviews. Sociodemographic data were described, and a thematic content analysis was carried out. ***Results***: From 2007-2011, 1,059 users started attending PAS, most of them women, middle-aged adults with low income and high prevalence of chronic non-communicable diseases. From the users' perspective, PAS allowed accessing health promotion actions in PHC, making it possible to develop healthier choices and changes in the way of life, mainly those related to physical activity and healthy eating, empowering users. However, limitations were identified in the integration between PAS and the assigned Basic Health Unit. ***Conclusion***: PAS has the potential to foster access to health promotion actions in PHC, although greater integration with other health care points is still needed in order to strengthen integral care networking and health promotion actions.

Keywords: Primary Health Care, Access to Health Services, Health Promotion, Health Integrality.

Resumo

Introdução: A situação de saúde marcada pela elevada prevalência de doenças crônicas não transmissíveis revela a necessidade de reestruturar a atenção à saúde. Nesse sentido, serviços como o Programa Academia da Saúde (PAS) foram implantados na Atenção Primária à Saúde (APS) brasileira. ***Objetivo***: Analisar, sob a perspectiva dos usuários, o PAS como oportunidade de redução das desigualdades de acesso às ações de promoção da saúde na APS. ***Método***: Trata-se de estudo qualitativo realizado na primeira unidade do PAS implantada em Belo Horizonte-MG, com ingressantes no serviço entre 2007 a 2011. A coleta de dados foi realizada mediante entrevista semiestruturada. Realizaram-se descrição dos dados sociodemográficos e análise de conteúdo do tipo temática. ***Resultado***: Ingressaram no PAS, entre 2007 e 2011, 1.059 usuários, a maioria mulheres, adultos de meia idade, com baixa renda e elevadas prevalências de doenças crônicas não transmissíveis. Na

perspectiva dos usuários, o PAS possibilitou o acesso às ações de promoção da saúde na APS, oportunizando a construção de escolhas mais saudáveis e mudanças nos modos de viver, sobretudo relacionados à atividade física e alimentação adequada e saudável, promovendo o empoderamento dos usuários. No entanto, foram identificadas limitações na integração do PAS com a Unidade Básica de Saúde adstrita. *Conclusão*: O PAS tem potencial para favorecer o acesso às ações de promoção da saúde na APS, embora ainda seja necessária maior integração com os demais pontos de atenção à saúde visando fortalecer o cuidado integral em rede e as ações de promoção da saúde.

Palavras-chave: Atenção Primária à Saúde. Acesso aos Serviços de Saúde. Promoção da Saúde. Integralidade em Saúde.

INTRODUCTION

The current health context, outlined by the increased prevalence of chronic non-communicable diseases, points to the urgent need of improving health promotion actions, particularly in more vulnerable territories.[1,2] World Health Organization (WHO) recommends structural renovations in health public services to ensure healthy cities, with basic needs addressed; universal access to health-disease care, and high level of public health.[3] Such characteristics can be fostered by extending access to health promotion actions and strengthening Primary Health Care (PHC), with focus on the action on health determiners.[4]

However, access to health promotion actions is still unequal. It is noteworthy that inequality in health is about measurable and perceived differences of health conditions related to the differences in access to health promotion, prevention or treatment.[5] Inequality in access to public services is even more evident in vulnerable areas, where there are insufficient spaces focused on the health care demands of that population.[3]

A study that assessed the nutritional profile of PHC users who lived in socially vulnerable areas in a Brazilian large city showed that those users had inadequate consumption of vegetables and ultra-processed food (candies, soft drinks, artificial juices and sausages), and high prevalence of chronic non-communicable diseases.[6] Thus, the population is exposed to the "cruel, harmful effects on one's own existence", which may result in the increase of sedentary behavior, in poor nutrition, in the high prevalence of diseases and in the reduction of life expectancy.[5]

In this sense, Brazilian government has invested in the expansion of actions for promoting health, prevention and control of problems in the public health services.[7] One of the adopted strategies was the creation of a new health care point, the Health Academy Program (PAS), structured as the area and equipment of the PHC and established in the Public Health System (SUS) in 2011.[7,8] PAS is aimed at strengthening, integrating and expanding the access of population to health promotion actions. For this purpose, it intends to manage its actions in a way to ensure access for all citizens. In order to do that, it must be organized and located near a Basic Health Unit (herein UBS), health service responsible for organizing care in the Health Care Network.[8]

Access to health services is the direction users take to seek answers to their problems, and PHC is the preferred gateway in the network.[9] In this context, PAS can contribute in an innovative way with the UBS to help the population solve their deficiencies, solve their problems and in the continued attention to promote their health.[10]

Focusing on the importance of the access of population to health promotion actions and the still recent implementation of PAS in Brazil, the purpose of this study was to analyze PAS as an opportunity to reduce inequality in accessing health promotion actions in the Brazilian PHC under the user's perspective.

MATERIALS AND METHODS

This is a qualitative study carried out in Belo Horizonte, MG, Brazil, the sixth largest city in Brazil, with a population of 2,479,165,[10] Human Development Index 0.810 and Gini Index 0.6106.[11]

The studied PAS unit was opened in 2006 and is the first one in the city, serving as an inspiration for the creation of the program nationwide. It is located in a vulnerable area and next to the UBS, decisive criteria for the first unit in the city.[12,13] The unit has infrastructure and qualified physical education professionals to offer activities aimed at improving body awareness, flexibility, strength and general motor coordination, such as dance, games and guided walk. Users start using the service spontaneously or by recommendation of the services of the Health Care Network. In a first contact, users go under a physical assessment so as to guide the activities according to their health needs and physical condition.[13] As well as in the year the study was carried out, nowadays the activities offered by PAS in Belo Horizonte are mostly focused on offering physical exercise, available to the users in three one-hour sessions a

week. Additionally, other health promotion actions are offered, such as the promotion of adequate, healthy eating, among others.[14]

For data collection, the first step taken was to trace the profile of all PAS users. The ones considered eligible were those who started attending the program between January 2007 and December 2011, and who attended the activities offered by the service in the last month.

Data for tracing user profiles were obtained from the analysis of the protocol used in the service, with the following variables: sociodemographics (sex, age, average income in minimum wages of the current year and education background), health conditions (self-declared presence of chronic non-communicable diseases and use of medication) and nutritional status (Body mass index – BMI = weight/height²). A descriptive analysis was carried out in quantitative data, including frequency distribution, and the calculation of median and interquartile range.

After characterizing users, subjects from the qualitative research according to the year they started attending PAS (2007 to 2011) were randomly selected. Such selection derived from the understanding that users with more experience in the practices offered by the service could contribute more.

Interviews were carried out within the facilities of PAS in March 2012. Subjects were randomized, with Excel software, from the data that listed all participants of PAS, and those with cognitive limitations that could impair the interview were excluded. Participants were stratified according to the year they started using the service (2007 to 2011), and 6 subjects for each year were selected, totaling 30 persons that could potentially take part in the study. There was no previous delimitation of the total of interviewed, which was defined in the course of the research, according to data saturation criteria. Thus, 19 users were interviewed. In the qualitative research, it is not necessary to classify the sample according to numerical criteria, considering that depth and coverage of the studied case were the essential concern.[15]

For the collection of qualitative data, individual semi-structured interviews were applied.[16] The interview is understood as a methodical procedure, with scientific purposes, through which the interviewees provide verbal information by answering a series of intentional questions or communicated stimuli. The researchers face the interviewees and ask them questions to obtain information that contribute do the investigation. It is an asymmetric dialogue, in which the researcher seeks collecting data and the interlocutor is an information source.[16,17]

Qualitative data were treated and analyzed through content analysis by following the chronological poles proposed by Bardin,[15] namely: pre-analysis, exploration of material and treatment of results, inference and interpretation. Firstly, the interviews were fully transcribed according to the semi-structured script, the material was thoroughly re-read and the reports were organized. Afterwards, the material was coded, and the corpus was defined, composing the thematic categories. The results were then treated, inferred and interpreted, based on a discussion with literature.

The study was approved by the Research Ethics Committees of the University (103/2007) and of the Municipal Government (087/2007), and all participants were informed of the benefits and risks of the research, voluntarily signing the Informed Consent Form.

RESULTS AND DISCUSSION

The purpose of this study was to analyze PAS as an opportunity for reducing unequal access to health promotion actions in PHC from the users' perspective. In order to do that, it was important to know the population served by the Program and then to understand the PAS performance in the context of a health system, particularly its potentialities and limitations as perceived by users.

Population studied

From 2007 to 2011, that is to say, since PAS opening until data collection, 1059 users started attending the service, mostly women, middle-aged adults, low income and with chronic non-communicable diseases (table 1).

Table 1. Sociodemographics and health characteristics of users of Health Academy Program from 2007 to 2011. Belo Horizonte-MG, Brasil.

Sample	Total (n=1059)	2007 (n=353)	2008 (n=170)	2009 (n= 210)	2010 (n=196)	2011 (n=130)
Sex (%)						
Women	89	89.2	88.2	92.4	88.3	84.6
Men	11	10.8	11.8	7.6	11.7	15.4
Age (years)[a]	49.3 (13.4)	49.7 (13.8)	48.8 (12.3)	49.0 (13.1)	49.7 (13.7)	51.3 (14.0)
Per Capita Income (%)						
<1 sm	66.2	NA	70.1	67.3	64.5	61.7
1 to <3 sm	32.4	NA	27.5	31.7	34.4	37.5
3 to <5 sm	1.2	NA	2.4	1	1.1	0
≥ 5 sm	0.1	NA	0	0	0	0.8
Education (years)[b]	8.0 (4.0;11.0)	NA	7.0 (4.0;11.0)	8.0 (4.0;11.0)	9.0 (4.0;11.0)	9.0 (5.0;11.0)
Number of chronic diseases (%)						
0	41.1	36.8	41.2	48.3	42.9	37.7
1 to 3	54.8	56.8	54.7	48.8	54.1	60.8
4+	4.1	6.4	4.1	2.9	3.1	1.5
Morbidity (%)						
High blood pressure	44.3	47.9	43.5	38.9	40.3	50.8
Hypercholesterolemia	29.6	32.1	22.6	30.3	31.6	27.9
Hypertriglyceridemia	15.1	16.1	14.6	12.5	15.7	16
Diabetes	11.6	15.6	8.9	6.4	13.5	10.2
Use of medication (%)	69.5	NA	67.6	64.6	71.4	76.9
Nutritional status(%)						
Underweight	1.6	1.7	1.2	0.5	2.7	1.7
Eutrophia	25.5	21.0	31.0	30.7	23.5	25.8
Overweight	72.9	77.3	67.9	68.8	73.8	72.5

Note: NA: not applicable, absence of information of users who started in 2007; sm: minimum wage.[a]Average (standard deviation). [b]Median (P25; P75)

Given the inequality characteristics of the territory (high health vulnerability) and of the users (mostly women and with low income) of the PAS, the importance of its implementation is highlighted, especially when considering the lack of initiatives that expand practices and experiences for promoting population health.[18] The presence of PAS in that community may contribute to the expansion of the access to health promotion actions,[19,20] in addition to corroborating principles established by the health public policies that seek reducing health inequality among individuals and communities.[21] It is known that actions aimed at health promotion, because of its intrinsic relation with the territory, have potential to reduce inequality.[22] In this sense, the insertion of PAS in the studied community has that potentiality.

The decrease in the number of new PAS users through the years (Table 1) may be related to the very capacity of the service (an average of 300 persons) deriving from the retention of participants through time. Although PAS is

a service with great capacity, there are structural limitations for an expansion (physical space and equipment),[23] being necessary to expand units in the entire city in order to increase its coverage and positive effects. Corroborating this perspective, in 2019 there were 78 units, serving around 19,000 persons.[14]

PAS was designed in SUS as an opportunity to increase access to health promotion actions. However, the predominant condition of diseases and use of medication among participants may reinforce the hypothesis that the subjects do access health services, particularly seeking treatment and cure, since the guidelines for treating chronic non-communicable diseases establish changes in physical activities and eating habits.[7] Thus, the feasibility of PAS as a strategy to promote health may be weakened.

Apparently, the Brazilian PHC still acts over the logic of treating diseases instead of preventing them or promoting health. Changing such logic depends on the reorientation of the services, but especially on the organization of the population to discuss health services and projects. The creation of community spaces of generational exchange among people with different professions and social conditions in order to articulate health needs, equipment available in the territory, whether public or private (schools, health care services, public safety, churches, clubs, among others), may contribute a lot for the organization of the community's social participation.[3]

As for the quantitative analysis of the study, 19 users were interviewed according to the different years of entrance (2007-2011), meeting data saturation criteria. By analyzing the reports, the following thematic categories were found: Access to health promotion actions; Potentialities of PAS for users; and PAS in the context of a health system: limitations.

Access to health promotion actions

PAS, once conceived according to the assumptions of health promotion and as a space to promote health choices and environments,[7,19] provides different activities, including physical, leisure, food and nutrition education by health professionals,[6] as seen in users' reports:

> Ah, besides to physical exercises, we have workshops... Workshops on eating guidance, hygiene... There are so many good things! (E2)
> There are several activities here. Standing on the step is the best one. Everybody is good. There are good parties. Nutritionists come and talk about ways of eating, it helps a lot. (E10)
>
> There are exercises with weights, weightlifting, aerobics, run, walk. When we are in Carnival time, we do dynamics, plays, June parties, even on Children's day we become children again, so the activities are varied.

Users reported performing health promotion activities in PAS, but the offer was not homogeneous among participants. Most of them (42.0%%) reported taking part only in physical exercise and leisure moments, such as tours and parties; 16.0% mentioned physical exercise, leisure and activities on food and nutrition; and 11.0% mentioned physical exercise and activities on food and nutrition.

One of the hypotheses for the major availability of physical exercise is due to the fact that the municipal government hires only physical educators to act directly in the service, and all other PHC professionals were responsible for the matricial support to the activities. Other possibility may be the influence of a prescriptive culture and preventive vision of health promotion by users, professionals and administrators, limiting the health promotion actions to two branches: physical exercise and nutrition.[23]

Remnants of the traditional logic, based on preventive and therapeutic actions, may be present in the service. Thus, educational activities based on risk factors (physical inactivity and poor nutrition) may be the priority, not covering the amplitude of social health determination. Additionally, the model on which the service is based – offer regular practice of physical exercises with a daily attendance control – may contribute to user retention and to building the perception of this practice as a key to promote, maintain and recover health.[13,23]

However, it is undeniable that PAS is important in reducing barriers that prevent users in vulnerable territories from accessing regular practices of physical exercise, leisure moments, and activities on food and nutrition, whether by the lack of proper public spaces or by social inequalities.[7,13,23] Ratifying the importance of the insertion of a public health program such as PAS in vulnerable areas, a study with users of a UBA in São Paulo showed inadequacies in the conditions of the physical activity programs, including insufficient hours of service and centrality on sickening.[24] In spite of the infrastructural barriers, the implementation of PAS is an important action for reducing unequal access to physical health promotion actions, considering the uncontrolled urbanization that impairs movement practices in the big cities.[4]

In Brazil, actions for promoting physical health and proper, healthy nutrition have been part of the health promotion agendas through the National Health Promotion Policy (herein PNPS),[25] and management of chronic non-communicable diseases through several PHC actions. [26] A systematic review of the programs for promoting physical activities SUS showed that 47% of them had a multi-professional team. Their objective was to promote health and a healthy lifestyle, as well as to increase the levels of physical activity and to improve life quality. Those programs worked in public spaces, such as squares, parks, avenues, bicycle lanes, beaches, and schools.[27]

Actions for promoting proper, healthy nutrition are also the focus of the National Policy on Food and Nutrition (herein PNAN), according to which PHC teams should perform actions on education and counseling in individual or group appointments, supported by the official guidelines in the Food Guide for the Brazilian Population. In this sense, it is worth to highlight the different strategies, among which PAS.[28] In fact, this study identified the offer of actions to promote proper, healthy nutrition as one of the main activities in the studied PAS.

In addition to mentioning health promotion actions related to the physical and biological aspect, the interviewees also reported the positive influence of the program in social aspects. Under their perspective, PAS is a place for relationships, exchanges and learning, where social interaction is emphasized, interfering positively in health and quality of life. Those matters are barely reported in the experiences in other health services:

> The academy of health is everything to me. After God it is everything. Because I feel very well here, I feel that I interact more and participate more. It is the best thing that happened in my life... It is a part of an accomplishment to me. (E1)
> For wellness... It is a type of leisure. (E8)
>
> So I feel well. So I can have a motivation to live! Because I was very sad, I was starting to have depression and now it is better. (E19)
>
> It is a motivator, of eating, of how it is necessary to do physical exercise, to walk and to stretch. And now I can't stop, I can't. (E19)

PAS, in this way, accomplishes to promote health by developing individual skills, reinforcing collective actions and providing an environment favorable to users, especially for self-care,[2,4] in accordance with the principles of health promotion. And because it is installed in the community territory, it is also a strategy capable of contributing to the expansion of access to health promotion actions, especially in places where social inequality prevails, reinforcing bonds among and with the subjects in the seek for an autonomous health development.

Therefore, PAS is a community space capable of meeting the demands of health, culture and leisure in the community;[3] and a strategy for tackling problems of health[5] and of access to the health promotion activities, which consequently improves life quality. It is worth to highlight that life quality is related to the access not only to health services, but also to healthy environments, support networks, and to the control of stigmas according to the requirements of each portion of the population and their sociocultural references.[3]

Potentialities of PAS for users

The positive perception that users have about PAS seems to be determinant so that they keep the bond with the service, experiencing a healthy environment and friendship, having a leisure moment and feeling "well treated" by the professionals. However, they also reported motivations related to setting goals, losing weight, normalizing health parameters (blood pressure, blood sugar and cholesterol levels) and empowering:

> I feel very well, I have many friends and I am recognized. This is very important to me. (E1)
> And I feel very brave, I feel more woman, I feel like that person that goes "I can, I can do it", you know? Wow, and I feel powerful! [laughs] (E7)
>
> Ah, I feel good, really good, you can have a problem at home then you come here and start exercising, chatting, doing those things, you even forget. It is like you get out of the world outside, then when you are going back home you go: Hey... I'm back to my world... (E13)
>
> Look, it is because I feel well, I get home joyful, satisfied, happy, willing to work. (E11)
> To keep in shape, because I saw It was very good to me. Because I lost some weight and I am more eager to live! (E1)
>
> Look, my blood sugar was high, blood pressure was high... Then I started coming here and everything went back to normal. (E2).

As seen in the interviews, PAS is also a space for reflection about the problems and for empowerment, in a way that users feel powerful, without problems. The program, in addition to offering activities according to the health needs, as seen in the testimonials about controlling blood pressure, blood sugar and weight, also approaches matters related to the users' context, crossed by the presence of chronic non-communicable diseases and unequal access to health promotion actions, particularly to regular, oriented physical exercise. In this sense, PAS is a strategy that intends to include the population of vulnerable territories in a broader sense, enabling individuals and community to deal with the social and health limitations and barriers, empowering them.[29]

In this perspective, it is noticed that PAS also strengthens the relationship between professionals and users and provides empowerment,[30] as seen in the following report:

> You know, when I talk to them [doctors], because when I went to the doctor before, he would say: "Do you exercise?" And I didn't, and I was ashamed of saying that. Now I have activities almost every day, and I say it, with a touch of pride. They tell us to continue, to keep it, they praise us a lot. (E12)

When asked about the reasons why they stopped attending the service, they mention private matters, such as trips, or health conditions that demand rest, as also seen in other study.[31] However, they all returned to PAS as soon as their problems were solved, which highlights the potentialities of PAS for meeting users' health demands and promoting retention:

> I stopped about fifteen days ago because of my tendinitis, the doctor told me to stop to see the exam results. When he received the results, he released me to do it, he told me to stretch my foot a lot, he put some medicine, and I returned quickly, on the following day. (E16).

We do not deny the infrastructural and coverage limitations related to the program, which, for example, limits the admission of new users to the service. However, when considering the lack of opportunities of leisure, regular exercise, social interaction and promotion of proper, healthy nutrition in vulnerable territories, PAS is a unique opportunity, and users say it should be used continuously.

PAS in the context of a health system: limitations

As a health promotion strategy by SUS, PAS is offered in the community in a universal way and for free, even absorbing users of supplementary health. In this respect, half of the interviewees (57.9%) had health insurance, demonstrating the capacity of PAS of broadly absorbing different neglected needs of the population.

Although the service is offered for free in the community, when the participants were asked about the SUS services they knew, most of them mentioned different medical specialties and the distribution of medicines by the UBS, as well as vaccination, exams, specialty consultations and medical center, and PAS is barely mentioned in that menu of activities.

> The SUS service that I know is only medication distribution. Because I have health insurance, I use the services it provides. (E1)

> Oh, thank God I almost don't use it. I used it when my girls were very young, just for vaccination... (E4)

> Oh, there are several: cardiologist, endocrinologist, pneumatologist, gynecologist and pediatrician. I only know those ones. (E9)

> Medical center, health center, I have health insurance, you know? I don't go to health centers, I get medicines there, once I had to take an injection, you just go and take it. (E11)

Only one user mentioned PAS as a service provided by SUS.

> Health center, right? The Academy of Health and physiotherapy. (E6).

On the other hand, when asked directly if PAS was part of SUS, 84.0% of the answers were Yes. The reports covered aspects such as the effectiveness of the system in reducing the use of medication and the occupancy of the UBS, having an agreement with the municipality, and referrals by its professionals to the UBS.

> I do. Because the academy is an agreement, an agreement with SUS. Because you go ther, attend the consultation, take your treatment there and continue taking treatment in the academy too, because the academy provides you with wellness and SUS has the medications, right? So both work together. (E11)

> When we started here with the academy, the then manager [UBS] came and commented how the number of people seeking medications for cholesterol, for hypertension, had decreased... (E13).

Users associated PAS to SUS because the service is somehow associated with the UBS, statement that is aligned with the guidelines of the Health Care Networks. Furthermore, it can be seen in the reports that PAS also

seems to ease access of users to the UBS. However, most of the time the arguments did not mention PAS as part of a complex network, thoroughly planned to meet the health demands of the population, in cooperation with the other services offered by SUS.[32-34]

As for the access, PAS, as a service provided by SUS, must ensure universal access to all citizens, in an ordered, organized way. In the studied unit, the admission of users occurred mostly because of recommendation by acquaintances (79.0%), living near the service (16.0%), and only 5.0% reported a referral by a professional of the Health Care Network. Such results may suggest that the contribution of the PHC professionals in enabling access to PAS was incipient, as seen in other Brazilian city:[31]

> Through a friend of mine. She would tell me it was very good, and that I had to come, and I ended up excited about it... (E7)

> Because I live near here, and from up there I could see the movement, and then I decided to come and check out what was happening down here. (E1)

The work of the health professionals in the articulation of the Health Care Network, following up and encouraging users to participate in PAS, seemed fragile. Under the perception of users, the participation of the professionals of the UBS in PAS activities and vice-versa is insufficient, being far from the guidelines by the integral care networking.[33]

FINAL CONSIDERATIONS

This study analyzes PAS in its implementation, as well as its relevance in reducing unequal access to health promotion actions in vulnerable territories. Such characteristics make it relevant, especially because of the need to investigate the potentiality of PAS in promoting health in the scope of SUS. The results may even help the municipality in planning the service, including activities offered to the community, with special attention given to chronic non-communicable diseases, and to the necessary expansion of the integration of the program with other health care points.

However, this study has limitations. It requires care when extrapolating the results, since the studied service is mainly focused on offering regular exercise, which may differ from other PAS units in the country. In addition, the study was developed in the first PAS installed in the city, which may have influenced the results. On the other hand, results showed the importance of expanding the actions in the health care services as possible paths to tackle the challenges faced by SUS.

Although the users found it difficult to understand the actions of PAS in the context of SUS, they identified the program as a facilitated, humanized access to SUS and to the health promotion actions, improving equity in the health care provided by the PHC, particularly in less-favored, vulnerable areas with low socioeconomic level, such as the studied area. However, in PAS, despite being called a health promotion service, the healing demands have been taking up an important space in their actions, impairing the accomplishment of its final purpose. At the same time, the service also closes an important gap of PHC, namely it offers effective collective actions to recover health, that is to say, approaching light technologies for prevention and treatment of diseases, especially the chronic non-communicable ones, which require continuous care.

Other important aspect identified in this study, from the reports of the interviewees, is that PAS seems to overtake the biological logic of health promotion, with consequences on the socio-environmental aspect, with potential to empower users in the everyday chores. Thus, the results herein are clear indications for the continuity of investments in PAS by the Brazilian government, as well as point out potentialities and improvement opportunities,

although a greater integration in PHC is fundamental for the articulation with the Health Care Network, aiming at strengthening integral care. Moreover, they also identify the need to expand the menu of health promotion actions to more than physical exercise.

Finally, this study suggests that PAS reduces unequal access to health promotion actions in Brazilian PHC under the users' perspective. It is worth to highlight that this study discusses the reduction of unequal access to health promotion actions, particularly physical exercise, which had not been accessible enough to the population before the implementation of PAS in the territory. However, in order to actually being health promotion actions, it is fundamental that those be integrated in the health system network so as to develop users' autonomy in seeking reducing inequalities.

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Caram CS and Mendonça RD participated in data analysis and interpretation, draft of the article, approval of the final version for publication and guarantee of accuracy and completeness of any part of the work; Marques RJR: data analysis and interpretation, relevant critical review of the intellectual contents, approval of the final version for publication and guarantee of accuracy and completeness of any part of the work; Brito MJM and Lopes ACS participated in the relevant critical review of the intellectual contents, conception and project, approval of the final version for publication and guarantee of accuracy and completeness of any part of the work.

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