

The 'locus' of health oversight in Brazil's Unified Health System – a place between the knowledge and the practices of social mobilization

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Abstract *Supervision of a health system presupposes keeping an attentive eye on the health situation of populations, so as to understand health, illness and healthcare as indissociable manifestations of human existence. Taking this point of view, this article examines health practices from the basis of some of their processes of communication. These are markedly professional-centered in their logic, with their emphasis on scientific, vertical and authoritarian discourse, predominantly in the spaces of the Unified Health System (SUS). In the territory, the process of communication is determinant. As a result of social interaction in daily life, the communication process reterritorializes the elements of the social totality: people, companies, institutions are re-dimensioned in the logic. It is a characteristic space for activities that aim for a more horizontal and democratic flow of communication.*

Key words *Health practices, Social mobilization, Health Surveillance, Communication, Territorialization*

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Introduction

We are living in a historic period of profound alteration of the way of life of people and societies, which is the result of the accelerated globalization of the economy, with expansion and massive incorporation of new technologies and new technical processes, by the productive sectors all over the planet. Simultaneously, and as a result of this process, we see appropriation of local resources and intensification of the flows of information, materialities and people¹, calling for a re-ordering of society. In this context, we now look at and underline the new aspects and proposals that emerge from the practice of health surveillance.

The field began to exist in the 1980s as a criticism of the healthcare models – in effect until today – which had a medical-assistential, or public-health campaigning basis. The proposal aimed for a change in management and technical practices in healthcare, seeking redefinition of the subject, the object, the technological basis, the spaces of its activity and the process of work of this sector. Anchored on the concepts of democracy and social participation, health surveillance has as its proposal a horizontality of knowledge and practices, and imposes new forms of relationship in the sphere of work in health. The dialog between professionals, and between them and the population, is understood as essential for identification of needs of health and the planning of actions. Even if the place of oversight in health in the SUS presupposes dialog with the population, and also includes actions that apply on various levels (political, regulatory, social, environmental, etc.), in this article we question how health surveillance has interacted with society, especially from the point of view of territory. What communication strategies are used? And up to what point do these strategies obey the principles of democracy and participation that have initially been the basis for the field?

It is worth noting that the ‘locus’ of health surveillance is complex, and to understand it we need to examine it from the point of view of its role in the State and within the scope of governments. The various processes and technologies related to health surveillance are situated between knowledge, and practices².

In August 2016, at its 284th ordinary meeting, Brazil’s National Health Council (CNS), through its Resolution 535³, called the First National Health surveillance Conference, specifying municipal, macro-regional, state and national instances. The aim of the conference is to propose

guidelines for formulation of a national Health surveillance Policy, and for strengthening of the health surveillance programs and actions within the ambit of the SUS.

The central theme of the First Conference is “health surveillance: Law, Achievements, and Defense of a high-quality, Public SUS”³ – to be discussed from the basis of eight sub-themes, which include: debate on the role of health surveillance in individual and collective healthcare, integration of actions and processes of environmental oversight; epidemiological; health products; among others, the responsibilities of States and governments, and social participation in health surveillance, as well as other questions³. Considering this group of themes, we can infer and explore impasses and obstacles in communication which have been put in the way of full realization of the right to promotion of health.

The following is quoted from the *Fiocruz Plan for Confronting the Public Health Emergency of National Importance*⁴:

[...] the complex demographic, epidemiological and health picture, today, and its trends for the coming decades, are challenges to be considered in the planning of actions in health, including the dimensions of health promotion, healthcare, and health surveillance, always relying on the contributions from generation of scientific knowledge in a way that is articulated with the process of decision making [...] designed to induce a planned and integrated process [...] involving a group of social players whether in the ambit of the academic world, civil society, public or private institutions, directing efforts to confronting this public health situation [...].

Taking the position stated by Fiocruz as a point of departure, it is our understanding that health surveillance presupposes keeping an attentive eye on the situation of populations’ health, understanding health, illness and healthcare as indissociable manifestations of human existence. The ‘health’ of a given social group will at all times be the result of historical-cultural processes, and will indicate positive and/or negative accumulations of resources that produce quality of life. By putting the dynamics of the social interaction that take place in the population and in a territory into context, the essential conditions that define and limit the problems and the needs of healthcare and of those cared for become clearer^{5,6}.

From this point of view, we propose to examine health practices based on communication processes. According to Teixeira⁷, these are

essentially marked by a professional-centered logic, which gives a privileged position to scientific-style discourse, that is vertical and authoritarian, predominantly in the spaces of the Single Health System (SUS). Without taking a critical approach to this communication process we will forever be asking: How does health surveillance interact with society?

Health surveillance in the context of the territory

The question of the location and of the territory that is lived in emerges as a counterpart to globalization. The global order imposed on territories seeks to rationalize their use through single rules and laws that appropriate resources in the most varied places in the world. The local order, on the other hand, is associated to a collection of things, objects and actions that are contiguous, united by the territory and, as such, ruled by social interaction⁸. Organization is the result of solidarity produced by social interaction in face-to-face contexts.

In spite of these orders that are ruled by opposing laws and rationalities, one sees aspects of each side in the other. The global order is ruled by rationalities that are technical and operational, external to the day-to-day routine, and carried out at a distance. It bases itself on information, organizing the territories for the appropriation of their most varied types of resources by international capital. It is an order that de-territorializes, and which separates the center, which is external, and the place of local action, de-structuring and excluding populations through external rules, which generate consequences in relation to the power of those peoples over their life territories⁸.

The local order is a fruit of the social interaction in day-to-day life, of the “co-presence of neighborliness”, intimacy, emotion, cooperation and socialization, interdependence and contiguity⁸. It re-territorializes because it brings together all the elements of the social totality, people, companies, institutions, social and legal forms, in a single internal logic of what is lived locally⁸.

In this scenario, the processes of social mobilization based on the local order should incorporate theoretical and practical elements of the policy and the culture of the territory, recognizing them as devices for their being made effective. Knowledge of the rules, norms and laws that structure local order and powers often materializes also in the culture, making it possible to understand the problems and the needs, individual

and collective, in health. Further, based on the comprehension of the local order it is possible to impress meanings on the social order that favor mobilization, emancipation and community empowerment. The group of communicative devices identified in the territory opens the possibilities of cooperative meetings between people to build various forms of mobilization, and to empower the local capacity to collectively promote improvements in their conditions of life and health situation⁹.

In the records of the Third *Encontro de Geografia* (Geography Meeting) and the Sixth Human Sciences Week, Matheus Crespo¹⁰ refers to Santos, saying:

“The territory used is a complex whole where a web of complementary and conflicting relationships is woven. Hence the vigor of the concept, inviting procedural thought on the relations established between the place, the socio-spatial formation and the world. The territory used, seen as a whole, is a privileged field for analysis in that, on the one side, it reveals to us the global structure of society and, on the other, the very complexity of its use¹⁰.”

In *O Retorno do Território* (“The Return of the Territory”), Santos¹¹ emphasizes that:

a territory, today, may be made up of contiguous places or of places in a network. They are, however, the same places that form networks and form the day-to-day space [...] it is indispensable to insist on the need for systematic knowledge of the reality, through analytical treatment of this fundamental aspect that is the territory (the territory used, the use of the territory). Even more essential is to review the reality within, that is to say, interrogate its very constitution in this historical moment.

Thus, it becomes fundamental that health surveillance “moves in the direction of” the vulnerable territories, becoming aware of their reality, in the process of social mobilization that is here being postulated. Taking the category “territory” as a starting point, environmental health should be achieved as part of a sustainable process, which ensures the inclusion of different citizens in the process of development. Thus, mere immobilism is not proposed in the face of the dimensions of indetermination or uncertainties. The fundamental thing, rather than purging this “inconvenient fact”, as in the deterministic point of view, is to face it head-on as a dimension to be considered in the planning and design of the communication strategies. Pitta & Oliveira¹², when analyzing the process of communication, highlight the reflection, which helps in under-

standing what type of mobilization we are postulating, and also the solutions constructed on the basis of it:

*[...] in dealing with problems of health, for which the cultural dimension is increasingly relevant, the non-structured dimensions of these problems or their “imprecisions” always holds surprises: it is not always that social practices – or behaviors, as some would have it – are organized in the way intended by ‘government office’ strategists. This is due to their very nature of non-predictability, of uncertainty, or of a state of permanent tension between meanings, discourses and social practices. It is a non-instrumental and constitutive communicational dimension of the processes of health-illness and of social practices, and thus inherent to a heterogeneous and multifaceted range of day-to-day micro-decisions, which give concreteness to social actions, and micro-solutions – with a view, for example, to elimination of potential breeding places of mosquitoes [...]*¹².

In this matrix (Figure 1), the territorial notion and practices are considered central for the process of health surveillance. We judge it to be essential to work based on the assumptions in which empowerment, equity and sustainability retro-feed the local base interventions, taking as a

point of departure categories such as gender, ethnicity, generation and culture. Summing up, the traditional knowledge emerges from each social group that is in process of social mobilization, in the interior of the knowledge and practices of health surveillance.

Considering the questions until then brought up, we turn to discussion of reflections on what social mobilization is discussed where people, for example, affected by a public health crisis, are protagonists of necessary inflection to policies, eliminating the conditioning factors of the emergency, not yet evidenced by studies and research, which, we infer, are strongly influenced by the social determinants of health. There is, thus, the need to provoke new ways of mobilization that go beyond the sessions of joint combat of mosquitoes, although without omitting to continue them. It is necessary to ensure popular participation in the decision at the level of development of public policies; inclusion of health surveillance; healthcare; teaching, and maintenance of research investigations, which are today considered the great engine of quest for answers and solutions. It is of fundamental importance that the products of this health crisis incorporate greater empowerment of the population in the decisions

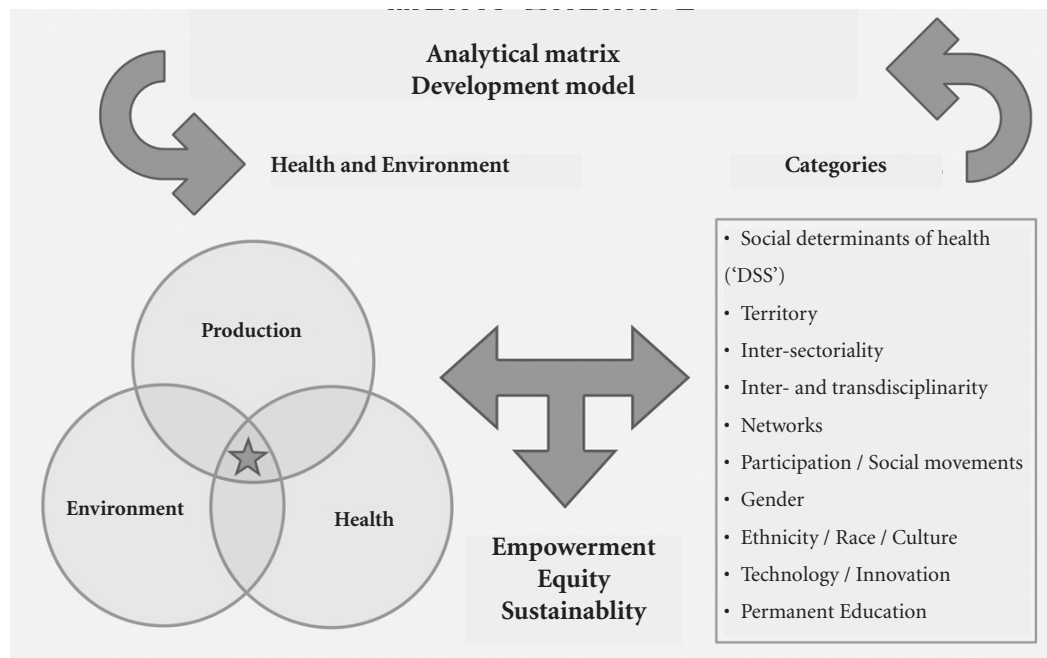


Figure 1. Social and environmental determination of the health situation.

taken in all these fields, strengthening responses that do not treat people as spectators of a narrative constructed by science, governments and the media. A narrative which, the great majority of times, excludes the voice of women/mothers (in the particular case, for example, of Zika), of the families and the population affected, that live and work in vulnerable territories.

We take as reference the document “Social mobilization: A way to build democracy and participation”, by Jose Bernardo Toro and Nisia Maria Duarte Werneck¹³, to affirm that social mobilization takes place when a group of people, a community or a society *decides and acts with a common objective, seeking, on a daily basis, results that are decided and desired by all of them*. In this logic, people can be invited to the mobilization but, in the last analysis, whether to participate or not is a decision for each individual. Continuing to quote the same document, the decision presupposes *a collective conviction of the importance, a sense of a public, of something that is convenient to all*. Thus, mobilization cannot be confused with advertising or publication, but requires communication actions in a broad sense, while as a process of sharing of discourse, visions and information.

We take as point of departure the idea of mobilization as a flow of dialogs, in which the voices of all sides are given equal value and have value for the common good to be achieved. All at once, the idea of unidirectional communication, and the verticality and monopoly of knowledge, which distances people from common interests and different methods of working, is ruptured. As Paulo Freire¹⁴, highlights, we are seeking dialogs, and not an “extension of the culture”.

Why we use the expression “between the knowledge and the practice” of communication

In our society, in many cases, the words knowledge and practice denote what one might even refer to as an “asset” of a specific group, instead of characterizing a “space for exchange”, in which communication is exercised, in its initial sense from the Latin *communicare*: “To make something known, to make it common property of parties, to pass to the other, to put into contact or relationship, to establish communication between, to link, unite, transmit, disseminate, give, grant, converse, live with, hold a dialog, reach an understanding”¹⁵.

If we transpose this to the environment of healthcare, we find multiple reflections: The re-

lationship of the health professional with the patient, the relationship between professionals of different levels, the institutional relationship of the health unit with the population served by it. In all these dimensions, one parts from the supposition that there are those “who know”, and those who “don’t know”, and it is for the first to “transmit” the information. This stance – which leaves out of account the knowledge held by the “other” – results in communicational practices that are unable to reach, or activate the sensitivity of, the interlocutor. As Teixeira⁷ expresses it:

“One cannot say that the general form of the relationship between the carers and the cared for that is currently in place in “health practices” is substantially different from the issuer-receiver relationship established in the “health communication practices” which take place under the sponsorship of the unilineal model. There is nothing that actually guarantees, as in the experiences in health education in the past, that the simple translation of information into health, even when translated into “popular rhetoric”, is capable, on its own, of producing the attitudes and behaviors expected by the institutions”.

The identification, in the territory, of communication groups and actions, is fundamental for incorporating the process of social mobilization, the elements of knowledge that are locally legitimized. These groups are players of the territory who, whether or not they have the support of local civic entities, increasingly produce community audiovisual material, radio and newspapers, blogs and sites, often disputing space – especially in the ambit of the territory – with the large and powerful mainstream media. They are key partners for local production and publication of content, and for organization of participative health surveillance¹⁶.

Depending on the articulation capacity of the groups in the territory, and of their access to the resources of communication, the greater, or the less will be their possibility of mobilization and democratic participation. Different forms of access to the community resources will have different effects in terms of capacity for mobilization. This will depend on the context and on the players involved. For example, a strong communicative capacity of a community radio station in a given territory can have a lesser effect than the same medium in another context, due, on the one side, to the cultural characteristics of the population in question, and on the other, to the different levels of community strength of each one of the players involved in the different contexts.

One also has to consider the groups that protagonize the most traditional and direct means of communication, based on face-to-face contact and the spoken word¹⁶, such as churches, clubs, graffiti artists, artistic groups, associations of every type, and the community support networks that operate in various sectors producing artefacts, literature, music and even an alternative economy. The action and discourses of these groups – often not very visible – are articulated in a network producing the places of life, listening to the “voice of the territories”. Their knowledge transforms relationships, and produces ideas of non-hegemonic culture that reaffirm the territories in their relationship with and day-to-day reproduction of social life¹⁶.

Strategies of social mobilization in the territories should identify and include these players whose power to operate and act socially through their technologies produce practices that appropriate the territory. The various ways of creating culture and of acting in communication involved in day-to-day life constitute a repertory to be considered in the production of contents for the territory^{16,17}. They are powerful devices capable of providing bases for processes of social mobilization in various contexts of social life. It is these contexts that will supply the base for preparation of a social mobilization discourse that is not only action, but above all communicative interaction.

Ricardo Teixeira⁷ makes an accusation that the type of communication practiced in health, which is one-direction and authoritarian in nature, is committed, among other issues, to the belief “in the use of the means as a possibility of extension of knowledge and mobilization of people, seeking adherence by the population to previously defined policies, programs and knowledge”, which approximates to what Paulo Freire¹⁴ refers to as cultural extension and invasion. Thus, a possible explanation for the low engagement of the population in the traditional “campaigns” of public health might be the vertical nature of the model, which places the population as mere spectator of previously defined actions¹⁸.

In an integrative review of 12 articles, Gonçalves et al.¹⁹ observed that there continues to be a lacuna to be filled, relating to empowerment of the population as active participant in the process, as opposed to the role of spectator of the official policy, in relation to knowledge, attitudes and practices of the Brazilian population in relation to dengue. They highlighted that the activity in the community should take into consideration the particularities of each con-

text; the need to horizontalize the process, and impose practices of continued education; the importance of developing a sense of responsibility and not of culpability, and of promoting the dialog between science and commonsense. They also highlight that the various elements of social knowledge serve as support for implementation of appropriate strategies, which take into account each community’s interests, needs, desires and vision of the world.

In the permanent construction of Brazilian health reform, social participation is defined as one of the central pillars, it being understood that without participation there is no transformation of health conditions. The health emergency that Brazil faced in 2015-16 has a strong component of gender, since women – especially pregnant women – are the main component mobilized by the informational alarms that were set off. From what the published data show, these women were from poor families, more heavily hit by the disease and by the outcome of congenital Zika in this health crisis.

In this sense, from the point of view of health surveillance, there are many possibilities of approach for the situation that these more vulnerable groups of people live through. When proposing an approximation to a new paradigm for epidemiology that is able to deal with “insubordinated” objects, Fernandes²⁰ upholds the thesis of Almeida Filho²¹ on the need for construction of an “ethnoepidemiology”, as an interdisciplinary practice and its assumptions that health-illness phenomena should be conceived as social, historic, complex, fragmented, conflictive, dependent, ambiguous, uncertain processes. Taking the premise of Santos²², we highlight the notion of space as a veritable field of forces whose formation is unequal, and this is why spatial evolution is not presented in the same way in all places. According to this author:

Space, due to its characteristics and its functioning, from what it offers to some and refuses to other [...] is the result of a collective praxis that reproduces social relationships, [...] space evolved by the movement of the society as a whole²².

Mapping voices: action and reflection on a territorial basis

Different authors approach the subject of social mapping (‘cartography’) as a way of approaching their subjects in their territories. Examining, principally, the articles of Ferigato and Carvalho²³ and Paulon and Romagnoli²⁴, meth-

odological elements arise that are essential to the postulates in this present article. Paulon and Romagnoli²⁴, parting from dialectical materialism, argue that knowledge is “the fruit of social multi-determinations [...] associating scientific-ness with politico-social practices”, supporting points of view on the processes of action and reflection on a territorial basis. Strengthened by Santos²⁵, the above authors underline the idea “of the effective contribution of scientific production to the construction of a better society”, reaffirming “an ethical-aesthetic commitment to life.”

Thus, we set out here the possibility of opting for a mapping of territorial voices, the speaking map of people who live and work in vulnerable territories, the same people in which health crisis is expanding. The outlook, expressed in this article, is in harmony with the understanding of Paulon and Romagnoli²⁴ that “technical knowledge only has its place when, deprived of any specialism, it is transmuted into a lever for self-management”. We use this assumption as a reference for the work of social mobilization that is proposed here. Completing the proposed conceptualization, we refer to Ferigato and Carvalho²³, starting from the contributions of Gilles Deleuze as a point of departure:

“The outline of an existential territory [...], collective, because it is relational; is political, because it involves interactions between forces [...]”. One thus concludes that mapping can be defined as the comprehension of the study of the relationships of forces that comprise a territory of experiences²⁶.

Thus, we direct the premise of social mapping as an explanatory map, for example, of the “geography of the arboviruses in Brazil”, which gets sharper outlines as from the vocalization of multiple players in various territories that have economic-political and social vulnerability. The social mobilization under discussion results, thus, from a permanent process of action and reflection, in which the dominant idea of the democratization of the means of mass communication take a part; the access to integral and distributed policies and to universal water and sewerage services, the fruit of an indispensable urban planning. In our proposal, between the knowledge and the practices that are mapped, a permanent process of social mobilization is constituted, drawn as the central idea of health surveillance, with broad participation by society.

Reflection for a territorial-based action

The concepts dealt with above are central but we move our focus to their process of operation in contexts of profound inequalities and social inequities in health. Thus, the central question in the drafting of this article comes down to “how to act”, speaking in methodological terms, in various territories amidst a health emergency, without the pretention to formulate a definite answer.

The existence of central categories could help us to formulate methodological strategies in relation to social mobilization, but particularly for action in the more vulnerable territories; in differentiated outlooks of socio-political participation of the local actors; taking as a starting point the preparation of maps of action, regional plenary sessions, in a process of work centered on the logic of rights. This way, it becomes necessary to elect something that interfaces all these dimensions. In our view, communication, popular and democratically based, should be the reference for the various work processes to be shared, feeding back the local practices and their consequent dissemination.

Incorporating new technologies of information is one of the challenges that appear in facing the health emergency, and the emergency in health surveillance, which is the subject of a special edition of *Ciência & Saúde Coletiva* [Science and Collective Health]. Relational technologies (popular plenary meetings and committees, conversation round tables), and even the use of technological devices (mobile devices, for example), can contribute to the strengthening of territorial-based solidarity networks. We propose discussion around the agglutinating, in-person and at-distance methodological elements, to facilitate exchange and swapping of local and regional answers, revisiting knowledge and practices in the ambit of the SUS, finding outlooks and differentiated forms of practices in health surveillance with wide participation of society.

Final considerations

The focus of our discussion is not new. Keyla Marzochi, in an editorial in *Caderno de Saúde Pública* in 1987²⁷, raised the fact that dengue, one of the very common arboviruses in our environment, was on the way to being transformed into “Brazilians’ newest pet endemic”. Three decades later, we re-examine the theme of health practice in which the key part of the question about the

interaction with society, in a certain way, remains without an answer. Are we adding new “pet endemics” to our list?

In parallel, it is worth also emphasizing the unique opportunity represented by the holding of the First National Health surveillance Conference (1st CNVS). The text of the invitation to the conference highlights that:

“To deal with the complexity of a country that urbanized rapidly and intensely, without structural reforms that could balance old and new social issues that generate profound inequalities, the need was found to overcome the model centered on vertical programs of supervision, prevention and control of illnesses, which until then had been coordinated and executed exclusively by the federal government”²⁸.

We see the points of view that we have emphasized over the course of this article as being strengthened and underlined – that health vigi-

lance programs and actions allow themselves to be permeated and renewed by the principles of mobilization and full social participation. In the present scenario, in which basic rights are toppled, and a conservative agenda is taking shape, to resume strengthening of the SUS is to set out the commitment to promotion of health, singularly with “the group of individual, collective and environmental interventions that are responsible for acting on the social determinants of health”²⁸, as the summary of the document expresses it.

Without social mobilization and full participation of society in the conception, implementation, monitoring and evaluation of Health surveillance, we will be condemned to go on acting in an episodic form in health crisis situations, as evidenced recently in the health crisis of 2015-16, continuing to disseminate in Brazilian culture and society “pet endemics”, which have haunted us for at least three decades.

Collaborations

AC Amorim, MC Castro, M Monken, and GMM Gordin contributed to the conception, outline structure of the study and critical revision of the content of the manuscript. JP Vicente da Silva, JV Sérgio, VR Fernandes and ZP Luz contributed to the research investigation, bibliographical revision and the process of analysis of the subject of health surveillance in the SUS and its interface with the questions of social mobilization and communication. All the authors took part in the drafting and approved the final version of the manuscript.

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