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Social control in the sectors of sanitation and health: a comparative analysis based on the Brazilian legal framework

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Abstract *Comparison between federal Brazilian legal frameworks in the areas of health and sanitation, from the perspective of participation, is the thread of this work, considering the pioneering of health and its possible influence on sanitation. The comparative effort was made from six analytical criteria: defined social control mechanisms; character given to social control; responsibility, recommendations and support to enable social control; access to information; control over the use of resources; control of the implementation of the resolutions. It was evaluated if the sanitation framework have been helped by health formulations and if have achieved produce more effective practices of social control in the conduct of public policy. The results show that, although it has received some influence from the health area, the water and sanitation framework is more restricted and has less potential to produce more effective practices, since it presents: 1) more restrictive mechanisms because they are not necessarily deliberative; 2) lack of a policy of training counselors and popular education to incentive participation; 3) absence of effective mechanisms for monitoring the use of resources.*

Key words *Water and sanitation, Health, Participation, Public resources, Legislation*

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Introduction

The central framework that institutionalizes social participation in Brazil is the Federal Constitution of 1988. In terms of the area of health, the subsequent legal consolidation of this institute, which was defined from 1990 onwards through infra-constitutional legislation, has received external influences, resulting from the Alma-Ata Conference, which instituted participation as a right and a duty[1].

In Brazil, certain factors were decisive in this achievement during a period that was strongly influenced by the fall of the military regime, such as pressure from social movements and grassroots ecclesial communities, as well as the demands of professional organizations for the re-democratization of the country. The Movement for Health Reform was particularly important in this respect. Political pressure aimed at creating a national public health system that was participatory, decentralized and of quality had been intensifying since the 1970s. The Movement for Health Reform, together with the Eighth National Health Conference, which was held in 1986, were the two main driving forces for progress in this area[2].

The construction of the framework that established participation in the area of sanitation began in 2004 and it is noteworthy that the issue of health was influential in discussions about the adoption of principles in relation to the provision of services, one of which was the issue of participation[3].

In spite of this achievement, due to the political and economic policies that have shaped Brazil since the 1990s (including the re-configuration of the process of the accumulation of capital and the commodification of some essential services, partially including the right to health[4-6]) the area of sanitation area was also affected. For example, the First Organic Health Law was enacted in 1990; however, the National Basic Sanitation Law (LNSB), which establishes the principles mentioned above, including the issue of participation through social control, was only enacted in 2007.

Thus, the question arises: in view of the above-mentioned political and economic policies, which continue to be exacerbated to the present day, in what specific aspects has the health framework influenced the sanitation framework insofar as the issue of social control is concerned? In order to answer this question, and in view of the aforementioned pioneering nature of the area of health, this article is based on a comparison between the federal legal frameworks of the two areas in question, from the perspective of social control.

This comparison, based on defined criteria, provides timely reflections about the feasibility of the sanitation framework being able to produce effective practices in terms of the conduct of related public policy, taking as a parameter the health framework, which is the product of an historical and progressive effort, but which has also been the object of counter-reforms promoted by forces that curtail social rights[4]. Consequently, this article is highly relevant because there are still few studies regarding this aspect of sanitation[7].

The following sections provide a conceptual discussion about social control, as well as a brief overview of Brazilian and international participatory practices in relation to sanitation and health. This is followed by the methodology, results, discussion and final considerations.

Social control

In the context of this article, social control is understood from the perspective of the relationship between the state and civil society according to the Gramscian theoretical apparatus. This means that the proposed analysis starts from three assumptions: 1) there is no separation between the state and civil society because they constitute an organic unit; civil society is a moment of the state and there is only a methodological separation; 2) civil society is not homogeneous, but rather a space where antagonistic interests circulate; and 3) the state, which maintains the dominant class, incorporates demands from the subaltern classes.

To understand the first of these presuppositions, it is important to be aware that, for Gramsci, the state exists both as a social totality and also in the narrower sense of the word. In terms of the latter, the state is also referred to as the coercion-state, or even political society, and it constitutes the locus of political power and the force of coercion. This includes coercive devices that are controlled by the executive bureaucracies and the military police. It corresponds to a moment of the state in a wider sense, as a social totality, together with civil society[8].

Thus, the restricted state and civil society form a 'unity in diversity'[8]. The distinction between the two is methodological and non-organic in nature, despite the fact that some contrary interpretations identify a dichotomy in this re-

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spect and deny the dialectical unity between politics and society[9].

Gramsci's notion of civil society is that it is composed of a group of private hegemonic apparatuses (schools, churches, unions and the media) and that it is a space in which ideological power is formed to exercise consensus and establish hegemony; in other words, a space in which the ideological values and norms of one social class predominate over the others, not by force, but by the culture that produced and diffused, and which is incorporated and assumed by those other classes[10,11].

Therefore, for Gramsci, the power of a class, rather than simply being linked to the control of the state apparatus, lies in its ability to intellectually and morally direct the whole of society and to generate consensus around itself. In this way, it exerts hegemony over the other classes and, as a consequence, it can eventually control the state[12].

Thus, the dominant class does not remain in power simply through coercive actions practiced by the state in its favor, but also by the consent of the subaltern classes on the margins of economic and political power[4]. These subaltern classes, which are surrounded by ideological sophisms, assert the hegemony of the dominant class through 'active consent'.

For Gramsci, relative to the subaltern classes, culture should 'be capable of breaking with its disintegration and opening the way for the construction of a collective will, in opposition to official conceptions of the world'[13]. In other words, this perspective references the construction of a new rationality, of a 'new civilization'[14].

Gramsci considers that the hegemony of the subaltern classes is a counter-hegemony brought about by the 'war of position', which is to occupy and besiege (and not to take by means of a 'war of movement') the state apparatus with a counter-hegemonic force created and diffused by the organization and culture of the working class[11].

In Gramsci's opinion, hegemony is related to power and to knowledge. He argues that the lack of a critical education facilitates the incorporation of the ideology of the dominant ruling class by the masses, and that the whole relation of hegemony constitutes a pedagogical action. However, he emphasizes that this pedagogical action is not merely limited to relationships in schools, at instructions or through the accumulation of notions[15]; it actually 'universalizes the capacity for critical thinking'[16].

In relation to the second assumption cited above, Gramsci considers that civil society is a space in which the previously mentioned private organizations represent disparate and non-homogeneous interests, elaborating and/or diffusing their ideologies, and entering into dispute between themselves by consensus and hegemony so that they may have influence over the state apparatus and, thus, have their demands responded to in the form of public policies.

Ideologies circulate within the heart of civil society; they are produced from the diverse and non-homogeneous interests of the various segments present in this arena of disputes[17]. Civil society is therefore heterogeneous in character 'and therefore - rather than being unified by common commitments and values - it is permeated by divergences and conflicts (...)'[18].

This characteristic also marks the subaltern classes, who dispute between themselves, and with the dominant classes, regarding consensus and hegemony. The limited success of social movements in Brazil since the 1990s, in contrast with the gains made by such movements in the previous decade[19], reveals that after achieving their common objectives that sustain the *collective* struggle, there is a change of focus, which is transferred to the *corporate* struggle, aimed at achieving specific and immediate objectives which are pertinent to each group or social segment[17].

In this sense, alliances emerge within civil society that are more corporate than collective; articulations between parts of their segments, and between the latter and political society, which can be understood as evidence of the 'war of position' for the construction of a counter-hegemonic movement in the dispute with non-allies, or which may represent the co-optation of these segments by the elites in order to maintain their hegemony.

This leads to discussion about the third above-mentioned assumption, in which Gramsci considers that within the enlarged state the restricted state assumes the role of maintaining the consensus and hegemony of the dominant class over the subaltern classes[11]. To this end, it even makes concessions to these subaltern classes, incorporating some of their demands and interests.

Thus, in view of these concessions, as well as the 'war of position' waged in civil society that is intended to besiege the state, the social control exerted by the subaltern classes is located. From this perspective, and for these classes, social control 'involves the capacity of organized social movements within civil society to interfere in public management, directing state actions and

state expenditures towards the interests of the majority of the population'[4].

Therefore, from the point of view of the subaltern classes, this control is a possibility since it depends on the correlation of forces within civil society that fight against the hegemony conquered by power. Thus, management councils and public policy conferences as mechanisms of social control, 'are not mechanisms above society, nor are they isolated instances immune to conflicts of interest, co-option, or disputes about the direction of social policy articulated to corporate projects, even if this is not explicit'[17].

Social control in sanitation and in health

Considering the Latin American panorama of social control in terms of sanitation, more specifically in relation to water supply services, makes it possible to identify trends that characterize the policies adopted in several countries. The practices that are involved, which shape the management of services and which change over time as a result of socioeconomic, political and cultural factors, are linked to the following models: 1) forms of non-participative technocratic management (service users are not seen as citizens or even as client-consumers, with the right to make themselves heard); 2) forms of management with restricted participation (some limited participation regarding consumer rights is permitted in a 'top-down' manner in limited spaces); 3) 'bottom-up' forms of participation (produced by workers, service users, communities and non-governmental organizations)[20].

The first of the aforementioned models corresponds to a tendency that was identified in Brazil during the military regime (1964-1985) and, to a great extent, even afterwards[21] because there are still examples of the strong influence of this model limiting the participation of service users[7,22,23]. This is also currently the situation in Mexico, among other countries[24]. This trend was also evident in Argentina from 1993-2006 during a period of mass privatization of services, which was marked by the total absence of popular participation; a situation which also occurred in Bolivia and Uruguay[25].

Some forms of restricted-participation management were put into practice in Argentina, especially in the late 1990s, as a concession to placate the growing discontent of the users of privatized services[26] , as well as in Mexico in the same decade[27], in Brazil since 2003 and in Bolivia from 1999-2006[20].

This type of participation also occurs within the European Economic Community (EEC) and in the United States. In the EEC, public consultation and mobilization are defined as participatory mechanisms in relation to water governance policy; however, there has been criticism of the capacity to integrate the results of discussions in the final decisions that are taken[28]. In the United States, there are references to the expansion of environmental jurisprudence, which has allowed claims that are based on motivations which are different from traditional personal economic interests[29].

Finally, in relation to the third of the models cited previously, examples of the 'bottom-up' type of participation have occurred in social mobilizations against the privatization of services in Argentina, Bolivia, Mexico, Nicaragua, Uruguay, Ecuador and Venezuela[30-32], Brazil[20] and Spain[33].

Within this same trend, other forms have occurred in Brazil that include participation through management councils and city conferences. Depending on the representative nature of social movements in the composition of the latter, among several other factors[34], participation may be more or less effective, approaching participatory management with restriction in the case of city conferences. This type of 'bottom-up' trend is also found in health care in several countries such as Italy[35], Portugal and Spain[36], England[37], Finland and New Zealand[38].

Methodology

This is a descriptive study[39] based on documentary analysis[40]. Detailed analysis of the electronic databases of the Ministry of Health, the National Health Council, the Ministry of Cities and the Council of Cities was used to identify the legal framework in relation to the theme of this article. Laws, decrees, resolutions and other federal regulations that establish guidelines, principles, obligations and regulations related to the exercise of social control were considered as part of this legal framework.

The analysis of this material was based on critical reading. This critical reading was focused on representative criteria of aspects relevant to the proposed approach, which revealed the modus operandi of social control in each area and which were identified from studies about health councils[6,34]. The criteria were as follows: 1) defined social control mechanisms; 2) the character conferred to social control; 3) the responsibility,

recommendations and support to enable social control; 4) access to information; 5) control over the use of available resources; and 6) control of the implementation of decisions.

The analysis made it possible to compare legal frameworks, identify devices that constitute advances in relation to each other, and to construct a response to the research question.

Results

The following are the legal frameworks in relation to social control in both areas, as well as their regulations, based on the six criteria that were used for the analysis.

With regard to the sanitation framework, Chart 1 indicates, in chronological order, the regulations that were identified:

Considering that, at the national level, the Council of Cities (ConCidades) represents the collegiate organ of social control in an area (Decree No. 5,790/2006, Article 3, Item 2 states that the Council must monitor and evaluate the implementation of the National Urban Development Policy, including sanitation), the following three resolutions are of interest for this study: Resolution No. 13/2004, which proposed guidelines for the exercise of social control; Administrative Resolution No. 02/2006, which created a working group composed of members of the Council of Cities to monitor the budget of the Ministry of Cities; and Recommended Resolution No. 75/2009, which established guidelines for the exercise of social control in sanitation planning. Also included in this list is the Council of Cities Internal Regulation, the text of which has been modified by various normative resolutions, the last of which was in 2011.

Completing this set of legislation, Law No. 11,445/2007, which corresponds to the LNSB, defined social control as a fundamental principle for the provision of sanitation services. Decrees No. 7,217/2010 and 8,211/2014 defined the application of this principle in greater detail. Law No. 12,305/2010 created the National Policy on Solid Waste (PNRS) and established it as the guiding principle of this policy, which was ratified by Decree No. 7,404/2010.

With regard to the health framework, Chart 2 lists the relevant laws, decrees and resolutions in chronological order.

The first component of this framework is the Federal Constitution of 1988, which deals with the *participation of the community* within the SUS. The other relevant legislation is as follows: Law No. 8,080/1990 (The First Organic Health Law), which concerns factors in relation to the promotion, protection and recovery of health, as well as the organization and operation of the corresponding services; Law No. 8,142/1990 (The Second Organic Health Law), which concerns community participation in SUS management and inter-governmental transfers of financial resources in the area of health; Decree

Chart 1. Legal framework of social control in relation to sanitation.

Identification	Year of publication
ConCidades Resolution No. 13	2004
ConCidades Administrative Resolution No. 2	2006
Law No 11,445	2007
ConCidades Recommended Resolution No. 75	2009
Decree No. 7,217 Law No. 12,305 Decree No. 7,404	2010
ConCidades Internal Regulation	2011
Decree No. 8,211	2014

Chart 2. Legal framework of social control in relation to health.

Identification	Year of publication
Federal Constitution	1988
Law No. 8,080 Law No. 8,142	1990
Decree No. 1,651	1995
CNS Resolution No. 354	2005
Decree No. 5,839 Ministerial Order No. 399 CNS Resolution No. 363	2006
CNS Resolution No. 407	2008
Ministerial Order No. 1,820	2009
CNS Resolution No. 435 CNS Internal Regulation	2010
Decree No. 7,508	2011
Complementary Law No. 141 Decree No. 7,827 CNS Resolution No. 453 CNS Resolution No. 454	2012

No. 1,651/1995, which regulates the National Audit System (SNA) within the SUS; Decree No. 5,839/2006, which provides for the organization, attributions and electoral process of the CNS; Ministerial Order No. 399/2006, which discloses the Pact for Health; Ministerial Order No. 1,820/2009, which provides for the rights and duties of health users; Decree No. 7,508/2011, which regulates Law No. 8,080/1990; Complementary Law No. 141/2012, which regulates Article 198, Paragraph 3 of the Constitution on values to invest in health; and Decree No. 7,827/2012, which regulates procedures for the transfer of resources.

The resolutions of the CNS are as follows: Resolution No. 354/2005, which approves the National Guidelines for the Process of Permanent Education in the Social Control of the Unified Health System; Resolution No. 363/2006, which approves the National Policy on Permanent Education for Social Control in the SUS, for implementation in the three spheres of government; Resolution No. 407/2008, which approves the CNS Internal Regulation; Resolution No. 435/2010, which amends the Internal Regulation of the CNS; the CNS Internal Rules; Resolution 453/2012, which defines guidelines for the institution, reformulation, restructuring and functioning of health councils; and Resolution No. 454/2012, which establishes routines and procedures aimed at permanent monitoring by the CNS of referrals and the implementation of the decisions approved in the National Health Conferences.

A critical reading of the two frameworks discussed above made it possible to identify the principal factors of interest for this study, which are summarized below in Chart 3.

Discussion

A comparison between the two legal frameworks, based on the defined criteria for analysis, is summarized below in Chart 4.

It can be seen that, apart from the criteria 'character conferred to social control' and 'control of the implementation of decisions', all the other criteria place more importance on the health framework than the sanitation framework because: 1) it defines mechanisms that are more democratic and deliberative, giving rise to the possibility of controlling the actions of the state by social movements which, when organized and represented, can act as part of a 'bottom-up' participatory movement[20]; 2) it expresses concern about the need to promote educational actions, both by counselors and the general population, in a movement that can stimulate the development of critical thinking[16]; 3) it determines the public access to information in order to control

Chart 3. The legal framework in relation to social control in sanitation and health.

Criterion	Sanitation	Health
Defined mechanisms of social control.	Debates, consultations and public hearings, consultative bodies and Conferences of Cities.	Participative health conferences. Permanent and deliberative health councils.
Character conferred to social control.	Fundamental principle of management. Condition of validity of service contracts. Condition of access to resources. Instrument of the PNRS.	Guideline and principle of the SUS. Condition of access to resources.
Responsibilities, recommendations and support to enable social control.	Responsibility of the holder. Participatory planning. Participation of SUS controling bodies.	Regulations for the CNS. Formation of counselors and popular education. Incentive to social control.
Access to information.	Creation of information systems in relation to services. Access to manual of service provision and attending to the public	Accounting and management of SUS by management bodies.
Control of the use of available resources.	ConCidades monitors and evaluates budget expenditure within the Ministry of Cities.	Health councils define guidelines for the use of resources and provide supervision.
Control of the implementation of decisions.	ConCidades monitors and evaluates the enactment of resolutions passed at the National Conferences of Cities and its resolutions.	Health councils monitor the referral and implementation of national conference decisions. Depends on approval of the Executive.

Chart 4. Comparison between the legal frameworks in relation to social control in sanitation and health.

Criterion	Comparison
Defined mechanisms of social control.	Health framework defines more democratic mechanisms (propositional and deliberative).
Character conferred to social control.	Both frameworks attribute social control as a principle and conditioner of actions.
Responsibilities, recommendations and support to enable social control.	Health framework highlights concerns about training counselors and popular education.
Access to information.	Health framework defines public access to information about the management of financial resources.
Control of the use of available resources.	Health framework establishes that councils define and oversee the use of resources.
Control of the implementation of decisions.	Sanitation framework defines a broader monitoring of the implementation of decisions.

the use of resources, which is recognized as a factor that favors social control[41].

Regarding the criterion 'character conferred to social control', the comparison reveals equivalence in terms of the documents that were studied. Both the health and sanitation frameworks highlight social control as a foundation for related actions and also as a condition of access to federal public resources. Likewise, social control is emphasized as a condition that validates the contracts for the provision of sanitation services, which is also contemplated in the health area, considering that the legislation determines that the SUS is managed - in general and without reservations – as an object of social control.

Thus, the importance given to social control in both frameworks is considered to be significant. However, the levels of consensus and hegemony that are established[10,11] will determine whether the subaltern classes will be able to direct the use of resources to meet their demands.

Regarding the criterion of 'control of the implementation of decisions', the sanitation framework was more advanced because in that framework there was more evidence of a concern to also monitor the implementation of the resolutions of the Plenary Council council, and not only those of the conferences, as was the case in the health framework.

Furthermore, the need for the approval of decisions by the SUS management at executive level is defined within the health framework, which can be understood as a restriction on social control[42], although it also states that in the case of non-approval the board may appeal to the Public Ministry. Bearing in mind the third assumption of Gramsci's apparatus, this fact corresponds to a limitation that is intended to ensure the continuation of the hegemony of the dominant class, despite the fact that, for example, the state incorporates the demands of service users within what constitutes the representation of civil society in the full council[11].

Despite this more positive aspect of the health framework compared with the sanitation framework, taking into account most of the criteria used in the analysis, it would be inappropriate and simplistic to conclude the discussion of these findings at this point without making some additional comments.

As previously mentioned, although the collegiate bodies are deliberative in nature in terms of health, their decisions depend on the approval of the Executive, as well as innumerable other factors that jeopardize their effectiveness[17,42-45]. On the other hand, in terms of sanitation, there are two issues that should be considered: 1) the possibility of municipalities making decisions regarding sanitation councils with no reference to the need for the approval of resolutions; 2) the existence of deliberative, collegiate bodies whose president is regimentally a representative of the Executive.

According to the provisions of Law No. 11,445/2007 (Art. 47) and Decree No. 7,217/2010 (Art. 34), social control in sanitation *may* be *of an advisory nature* through collegiate bodies. Thus, two different interpretations are possible: 1) the aforementioned law and decree only *allow* the creation of consultative collegiate bodies; 2) the aforementioned law and decree *suggest* the creation of consultative collegiate bodies and do not restrict the creation of deliberative collegiate bodies.

In terms of the first interpretation, this is the one proposed by the PRÓ-SINOS Consortium in a guidance document on the constitution of municipal sanitation councils for the municipalities that form part of the aforementioned organization[46].

However, in relation to ConCidades' Recommended Resolution No. 75/2009, which provides for the creation of deliberative collegiate bodies, this same document considers the possibility of municipalities choosing between what is set out in the aforementioned law and decree, and what is recommended by the aforementioned resolution; indirectly admitting the second interpretation.

If such a choice is dependent upon the creation of advisory councils, this does not confirm the possibility of equality between the two types of frameworks, since there is the possibility that the feeling may exist that people feel that they are participating in a discussion knowing that their opinions are unlikely to change any decisions that has already been taken by those in control. What might constitute a movement of the subaltern classes, or segments of them, to direct state actions and expenditures in the direction of their interests – which is the purpose of social control - is reduced, however strong it might be, to a pressure movement with greater or lesser impact on the state apparatus, which may or may not incorporate the demands in question.

Undoubtedly, this can be interpreted as an obstacle to, or even a curtailment of, social control by the subaltern classes because it is linked to the third presupposition of the Gramscian apparatus: the state incorporates the demands of the subaltern classes to maintain the hegemony of the dominant class. Consequently, the demand for participation in the formulation of policies and in the planning and evaluation of services is met, but only within certain limits that keep hegemonic interests safe.

There is, however, another aspect to be considered, which points not to a limitation to social control, but to a relativization of it. Bearing in mind that in the opinion of Gramsci, the power of a class, apart from being linked to the control of the state apparatus, lies in its ability to direct, both intellectually and morally, the whole of society and to generate consensus around itself, it can be argued that the previously mentioned social pressure movement is the result of the process of building a new consensus, which is significant in itself.

However, if the choice of the nature of the collegiate body rests on the creation of deliberative councils, the effectiveness of social control will not necessarily be assured. In this case, a number of factors come into play, such as regional, participatory experiences and traditions[47], and the obligation, established through the collegiate body's laws and internal regulations, that its presidency be exercised by a representative of the Executive. This, in itself, is a strong indication of the limitations imposed on the free action of the council[11,20].

Final considerations

In general, it can be seen that in terms of intensity of participation, the framework of social control in sanitation did not incorporate the advances achieved in the area of health, which can be described as follows: 1) more effective mechanisms for being propositional and deliberative; 2) a policy to train counselors and to provide popular education as an incentive and strengthening of social control; 3) mechanisms for the wider dissemination of financial accountability and SUS management; 4) express attributions to social control bodies regarding the supervision of the use of financial resources made available for health.

For this reason, and in spite of the difficulties of implementing the legal advances that were identified in the literature and the limitation that the health framework provides in comparison with the sanitation framework with regard to the control of the implementation of decisions, it can be considered that the health framework provides a greater possibility of producing more effective practices from the point of view of the subaltern classes.

This seems to indicate that the way forward should be a continuation of the 'war of position' in favor of a form of sanitation understood as a social right and duty of the state; a struggle which entered the fastest and most productive phase in 2003 and which, since 2016, requires intensification.

Since 2015 there have been many advances and ambiguities in the field of sanitation (the creation of ConCidades, the promulgation of the national legal framework, the implementation of public investment programs, the approval of the National Plan for Basic Sanitation) and the contribution of social control is required to consolidate and expand upon these advances in the long term.

At present, the relevance of social control is intensifying, given the radical neoliberal poli-

cies adopted by the Brazilian government which took office on August 31, 2016, aimed at freezing public expenditures and privatizing services, including sanitation, thereby increasing the need to establish a position contrary to the idea of sanitation as a commodity.

Furthermore, it is important to seek improvement within the legal framework in order to overcome its limitations, as well as aiding the most vulnerable segments of civil society (both service users and non-users) especially those in areas characterized by poor sanitation, so that they can act in a critical and democratic way, fighting against the status quo. Although it has its limitations, the health framework can be considered a supportive reference in this process.

Collaborations

CMN Souza and L Heller participated equally in all stages of preparation of the article.

References

1. Declaração de Alma-Ata. Conferência Internacional sobre Cuidados Primários de Saúde Alma-Ata, 1978. [acessado 2016 Dez 12]. Disponível em: http://cmdss2011.org/site/wp-content/uploads/2011/07/Declara%C3%A7%C3%A3o-Alma-Ata.pdf.
2. Costa AM, Vieira NA. Participação e controle social em saúde. In: Fundação Oswaldo Cruz. *A saúde no Brasil em 2030 - prospecção estratégica do sistema de saúde brasileiro*: *organização e gestão do sistema de saúde*. Vol. 3. Rio de Janeiro: Fiocruz/Ipea/Ministério da Saúde/Secretaria de Assuntos Estratégicos da Presidência da República, 2013. p. 237-271.
3. Borja PC; Moraes LRS. O acesso às ações e serviços de saneamento básico como um direito social. In: Ministério das Cidades/Secretaria Nacional de Saneamento Ambiental, organizadores. *Elaboração de Plano Municipal de Saneamento Básico. Guia do profissional em Treinamento: nível 2*. Salvador: ReCESA; 2008. p. 11-24.
4. Correia MVC. *Desafios para o controle social: subsídios para capacitação de conselheiros de saúde*. Rio de Janeiro: Editora Fiocruz; 2005.
5. Silva KS. Neoliberalismo e direitos humanos: trajetórias opostas. *Sequência* 1999; 20(39):96-113.
6. Correia MVC. *Que controle social? Os conselhos de saúde como instrumento*. Rio de Janeiro: Editora Fiocruz; 2000.
7. Piterman A. (A falta de) Controle social das políticas municipais de saneamento: um estudo em quatro municípios de Minas Gerais. *Saúde Soc*. 2013; 22(4):1180-1192.
8. Coutinho CN. O desafio dos que pensaram bem o Brasil. Como Pensar? *Lua Nova* 2001; (54):87-132.
9. Liguori G. O pensamento de Gramsci na época da mundialização. *Revista Novos Rumos* 2000; 15(32):4-15.
10. Macciocchi MA. *A favor de Gramsci*. Rio de Janeiro: Paz e Terra; 1980.
11. Carnoy M. *Estado e teoria política*. Campinas: Papirus; 1988.
12. Restrepo LA. A relação entre a sociedade civil e o Estado: elementos para uma fundamentação teórica do papel dos movimentos sociais na América Latina. *Tempo Social* 1990; 2(2):61-100.
13. Simionatto I. Classes subalternas, lutas de classe e hegemonia: uma abordagem gramsciana. *Revista Katályse* 2009; 12(1):41-49.
14. Dias EF. Hegemonia: nova civiltà ou domínio ideológico? *História e Perspectivas* 2014; 27(50):89-146.
15. Wanderley LEW. Sociedade civil e Gramsci: desafios teóricos e práticos. *Serviço Social e Sociologia* 2012; (109):5-30.
16. Acanda JL. *Sociedad civil y hegemonía*. La Habana: Centro de Investigación y Desarrollo de la Cultura Cubana Juan Marinello; 2002.
17. Bravo MIS, Correia MVC. Desafios do controle social na atualidade. *Serviço Social e Sociologia* 2012; (109):126-150.
18. Instituto de Pesquisa Econômica Aplicada (IPEA). *Estado, instituições e democracia: democracia*. Brasília: Ipea; 2010.
19. Gohn MG. *Movimentos sociais e educação*. São Paulo: Cortez; 2012.
20. Castro JE. *Água e democracia na América Latina*. Campina Grande: EDUEPB; 2016.
21. Heller L, Rezende SC, Heller PGB. Participação e controle social em saneamento básico: aspectos teórico-conceituais. In: Galvão Junior AC, Ximenes MMF. *Regulação: controle social da prestação dos serviços de água e esgoto*. Fortaleza: Pouchain Ramos, 2007.
22. Melo GB. *Avaliação da política municipal de saneamento ambiental de Alagoinhas (BA):contornos da participação e do controle social*. [dissertação]. Brasília: Universidade de Brasília; 2009. [acessado 2013 Jan 05]. Disponível em: http://repositorio.bce.unb.br/handle/10482/8961
23. Mello MCC, Rezende S. O Conselho Municipal de Saneamento de Belo Horizonte: desafios e possibilidades. *Eng Sanit Ambient* 2014; 19(4):479-488.

24. Castro JEC, Kloster K, Noguez MIS, Torregrosa ML. Ciudadanía y gobernabilidad en la cuenca del río Bravo-Grande. In: Jiménez B, Marín L. *El agua en Mexico vista desde la academia*. México: Academia Mexicana de Ciencias; 2005. p. 199-231.
25. Delcós J, Vila A. *Gestión pública del agua con participación y control social. Monográficos Agua en Centroamérica* [6]. Secretariado Alianza por el Agua / Ecología y Desarrollo. s/d.
26. Almansi F, Gutierrez E, Hardoy A, Pandiella G, Schusterman R, Urquiza G. *La lucha por acceder al agua. La titularidad de la tierra en la expansion de los servicios de agua potable y saneamiento en barrios informales – parte 1*. Buenos Aires: Internacional do Medio Ambicnte y Desarrollo IIED-América Latina; 2005.
27. Armentia MLT, Cisneros BJ. Challenges facing the universal access of water and sanitation in Mexico. In: Castro JE, Heller L, editors. *Water and sanitation services: public and management*. London: Earthscan, 2009. p. 338-347.
28. Schmidt L, Ferreira JG. *Avanços e desafios da governança da água na Europa no contexto da aplicação da directiva quadro da água*. 2014. [acessado 2016 Dez 12] Disponível: http://repositorio.ul.pt/handle/10451/12331?locale=en
29. Peña H, Solanes M. *Effective water governance in the Americas: a key issue*. 2003. [acessado 2016 Dez 12]. Disponível: http://www.cepal.org/drni/proyectos/samtac/drsam00303.pdf
30. Lacabana M, Cariola C. Construyendo la participación popular y una nueva cultura del agua en Venezuela. *Cuadernos del CENDES* 2005; 22(59):111-133.
31. Instituto de Estudos latino-americanos (IELA). Universidade Federal de Santa Catarina. *A Lei de água no Equador tem armadilhas para privatizar a água*. Florianópolis: IELA; 2014. [acessado 2016 Out 11]. Disponível: http://www.iela.ufsc.br/noticia/lei-de-aguas-no-equador-tem-armadilhas-para-privatizar-agua
32. Castro JE. An examination of the politics of privatization of water and sanitation services in Africa, Europe, and Latin America (1990-2004). *Waterlat-gobacit network working papers. Working Paper* 2016; 3(3).
33. Saurí D, Olcina J, Rico A. The state of urban water supply and sanitation in Spain: issues, debates and conflicts. In: Castro JE, Heller L, editors. *Water and sanitation services: public and management*. London: Earthscan; 2009. p. 207-216.
34. Machado JA, Lucas SD. Análise das resoluções do Conselho Municipal de Saúde de Belo Horizonte no período de 1991 a 2010. *Cien Saude Colet* 2013; 18(8):2401-2411.
35. Serapioni M, Duxbury N. Citizens participation in the Italian health-care system: the experience of the Mixed Advisory Committees. *Health Expectations* 2012; (17):488-499.
36. Serapioni M, Matos AR. *Os lugares da participação nos sistemas de saúde em países Sul Europeus. Praxis Sociológica* 2014; 18:81-100.
37. Serapioni M, Ferreira PL, Antunes P. Participação em Saúde: conceitos e conteúdos. *Notas Económicas* 2014; 26-40.
38. Serapioni M, Romaní O. Potencialidades e desafios da participação em instâncias colegiadas dos sistemas de saúde: os casos de Itália, Inglaterra e Brasil. *Cad Saude Publica* 2006; 22(11):2411-2421.
39. Appolinário F. *Dicionário de metodologia científica: um guia para a produção do conhecimento científico*. São Paulo: Atlas; 2007.
40. Gil AC. *Como elaborar projetos de pesquisa*. São Paulo: Atlas; 2002.
41. Brasil. Ministério da Saúde (MS). *Coletânea de comunicação e informação em saúde para o exercício do controle social*. Brasília: Editora do Ministério da Saúde; 2006.
42. Cotta RMM, Cazal MM, Rodrigues JFC. Participação, controle social e exercício da cidadania: a (des)informação como obstáculo à atuação dos conselheiros de saúde. *Physis Revista de Saúde Coletiva* 2009; 19(2):419-438.
43. Avritzer LA participação social no Nordeste. In: Avritzer L. *A participação social no Nordeste.* Belo Horizonte: Editora UFMG; 2007.
44. Cristo SCA. Controle social em saúde: o caso do Pará. *Serviço Social e Sociedade* 2012; (109):93-111.
45. Abers RN, Formiga-Johnsson RM, Frank B, Keck ME, Lemos MC. Inclusão, deliberação e controle: três dimensões de democracia nos comitês e consórcios de bacias hidrográficas no Brasil. *Ambiente e Sociedade* 2009; 12(1):115-132.
46. Pro-Sinos (Consórcio Público de Saneamento Básico da Bacia Hidrográfica do Rio dos Sinos). *Orientação sobre a constituição dos conselhos municipais de saneamento básico para os municípios integrantes do Consórcio Pró-Sinos*. São Leopoldo: Pró-sinos s/d. [acessado 2016 Fev 22]. Disponível em: http://www.consorcioprosinos.com.br/downloads/ocontrolesocialnosaneamentobasico.pdf.
47. Avritzer L. Sociedade civil e participação no Brasil democrático. In: Avritzer L. (organizador). *Experiências nacionais de participação social*. São Paulo: Cortez; 2009. p. 27-54.

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