Original articles

# The world of work is not automatic: what can operate as a device for managing care in small municipalities?[1]

## O mundo do trabalho não é automático: o que pode operar como dispositivo para a gestão do cuidado em municípios de pequeno porte?

**Paula Bertoluci Alves Pereira**[a]
https://orcid.org/0000-0002-7200-6335
E-mail: paulabertoluci@alumni.usp.br

**Laura Camargo Macruz Feuerwerker**[a]
https://orcid.org/0000-0001-6237-6167
E-mail: laura.macruz@gmail.com

[a] Universidade de São Paulo, Faculdade de Saúde Pública, Departamento de Política, Gestão e Saúde. São Paulo, SP, Brasil.

## Abstract

This article intends to explore experiences of devices for the management of care carried out by the management teams of small municipalities that can be learned in the production of knowledge and actions in the Brazilian National Health System. The cartographic approach was used to build the research field in two small municipalities in the state of São Paulo, covering different formal and non-formal health and intersectoral spaces in the period from 2018 to 2020. Analyzers were produced from the experience in the field and discussed in the light of the micropolitics of work and of health care, giving visibility to the fields of dispute, challenges, and powers of small municipalities. articulated with the problematization on the axis of comprehensiveness and of care management. The world of work is in full dispute for the living actors of the Brazilian National Health System, and is crossed by the established and by the hegemonic medical force. The manufacture of care management devices is fundamental to favor displacements and escapes in relation to captures that are many and diverse in the scope of work and care.

**Keywords:** Delivery of Health Care; Integrality in Health; Continuity of Patient Care; Local Health Strategies; Local Health Systems.

**Correspondence**
Paula Bertoluci Alves Pereira
Avenida Doutor Arnaldo, 715, Cerqueira César. São Paulo, SP, Brasil.
CEP 01246-904

## Resumo

Este artigo pretende explorar experiências de dispositivos para a gestão do cuidado fabricadas pelas equipes gestoras de municípios de pequeno porte que podem ser aprendizados na produção de conhecimento e fazeres no SUS. A abordagem cartográfica foi utilizada para a construção do campo de pesquisa em dois pequenos municípios do estado de São Paulo, percorrendo diferentes espaços, formais e não formais, da saúde e intersetoriais, no período de 2018 a 2020. Analisadores foram produzidos a partir da vivência no campo e discutidos à luz da micropolítica do trabalho e do cuidado em saúde, dando visibilidade aos campos de disputa, desafios e potências dos municípios pequenos articulado à problematização sobre o eixo da integralidade e da gestão do cuidado. O mundo do trabalho está em plena disputa pelos atores-viventes do Sistema Único de Saúde, sendo atravessado pelo instituído e pela força médico-hegemônica. A fabricação de dispositivos para a gestão do cuidado é fundamental para favorecer deslocamentos e escapes em relação às capturas que são muitas e diversas no âmbito do trabalho e cuidado.

**Palavras-chave:** Atenção à Saúde; Integralidade em Saúde; Longitudinalidade do Cuidado; Estratégias de Saúde Locais; Sistemas Locais de Saúde.

## Introduction

This study derives from the Ph.D. thesis entitled *Arrangements and devices for care management in small municipalities in the State of São Paulo: interlaces and knots* (Pereira, 2022), which aimed to give visibility and sayability to the bets, powers and challenges that permeate care management in small municipalities.

We used the cartographic approach to establish the research area to two small municipalities in São Paulo, namely Ouroeste and Santo Antônio de Posse. From 2018 to 2020, the research covered various formal and informal healthcare and intersectoral spaces. Some of them were indicated by managers and workers based on what they identified in the polysemy of care strategies, care management, and caregiving arrangements. Other approaches occurred as a result of events in the field, in action. A rhizome that branched out with each encounter, opening possibilities for new connections.

Implication was the hallmark of knowledge production, and the researcher adopted a questioning stance towards themselves and the moving field, which forms/dissolves/deviates/stems from, similar to an overly implicated individual (Merhy, 2004). The intention was to "in-world" oneself in the territories manufactured by the investigation, to interrogate and problematize what emerges from these encounters, creating space for life to flood these places, and recognizing the living actors in the field as active participants in the research, whether they be workers, managers, or users (Abrahão et al., 2014, 2016).

These unique dance-encounters left their marks, which were translated by this author into credible narratives (Henz, 2022), put into words and inviting reflection and unsettlement into some problematic/analytical fields. These stood out for the intensity of the lived experiences and were analyzed by the framework of work and healthcare micropolitics, drawing on contemporary philosophers such as Foucault and Deleuze.

This research was approved by the Ethics and Research Committee, opinion number CAAE 10037019.7.0000.5421.

## The problem in focus

Small municipalities, with up to 20,000 inhabitants, account for almost 70% of Brazilian municipalities, although only 15% of the population resides in them. Few studies analyze the arrangements and forms of care management and production in these places, despite representing a significant reality within the Brazilian National Health System (SUS).

Even though regional singularities exist, there is a certain structure of common forces that cut across the SUS experiences in small municipalities, implying regularities and differences in care and comprehensiveness production. These disputes interfere with the design of municipal and regional services, as well as with arrangements for care management, which are strongly affected by policies and regional tensions as well as by market forces, supplementary health, and socio-economic health inequalities. This entanglement of forces compels small municipalities, especially the most distant ones, to develop ways to manage care.

All municipalities, including small ones, have a fundamental and active role in the SUS production, being responsible for direct assistance and access coordination to different services, which are key elements to grant the universality and comprehensiveness of the system. Comprehensiveness entails network arrangements and depends on health concepts, as well as regional and interfederative connections. Even primary care, which is exclusively provided by the municipalities, presupposes tripartite co-financing and regulatory actions from different levels.

However, the municipalities are the ones directly facing pressure from citizens based on their health demands and needs; becoming the only sphere committed to increasing health expenditures in a scenario of chronic underfunding of the health system, which turned into de-financing when the spending caps at the federal level were instituted.

By "carrying SUS on their shoulders," unlike the widely portrayed caricature, managers of small municipalities face challenges that go beyond the basic health network, while simultaneously pointing to the need for its strengthening. On one hand, they are strongly activated by demands related to access to health services, mainly specialized and hospital service of medium and high complexity (MHC), as well as diagnostic and therapeutic support services. Their primary care services' capacity to respond effectively and coordinate care within a network interferes directly with this demand.

Due to the demand pressure forces and tensions in regional collaborations, several small municipalities end up diversifying the range of services they offer. Guerra (2015) points out that, in São Paulo, only one municipality abstained from using the MHC resource. All the remainder had at least one specialist and some services hired by the municipality, in an effort to overcome access and articulation bottlenecks.

The weaving of healthcare management is intimately linked to how we perceive the needs of the population, whether through the lens of restricted access to securing appointments or through the lens of the care comprehensiveness beyond the initial access movement. In SUS, as well as in other universal health systems, there is a crucial knot in accessing MHC services, and small municipalities are much more dependent on negotiated logics, since service offerings in these areas are mainly regional or state-based. However, focusing on the first "lens," which is limited to the problem of access to appointments, excludes intensities, disfavor continuity, and hinders care amplitude. When limited to the concern about access to consultations and exams, the trend is to produce fragmentation, unaccountability, queues, and care discontinuity.

The emphasis on the "lens of comprehensiveness" of care beyond access requires movements at the municipal and regional levels with the production of devices that expand and "extract" visibilities and sayabilities (Deleuze, 1990) from health and care actions. Managers who mobilize for comprehensiveness, foster the network, the lively articulation, involve people in creating lively dialogs and monitoring processes, and diversify arrangements. They pursue comprehensiveness ensuring transversal care. Along with teams acting as co-responsible for productive health actions, they are guided by light technology as paramount to listening, broader and contextualized consideration of needs, and responsible direction in an optimal and timely fashion. Thus, they access

health technologies according to what is needed, and coordinate different support modalities.

The concepts of comprehensiveness and care management complement each other and depend on each other, from the construction/mode of producing policies to the sense that care will resonate in the encounter between workers and users (Cecílio, 2011). Everyone is immersed in a dispute of forces, vectors, and the production of values marking the management stakes and their manager-mask-indentity. At times, the force of medical-hegemonic rationality prevails, at other times, the force of neoliberalism triumphs. Sometimes the force of self and other governance conquers; at other times, the force of needs screams louder.

Care management needs a device, it must be produced on the fly, otherwise, it becomes merely a response at the formal level. To provide care through paperwork (i.e., printed reference/counter-reference documents) is not effectively a networked approach. Hiring healthcare professionals and expanding the team does not guarantee shared care. Building a Primary Healthcare Unit or a small hospital does not guarantee it either.

According to Feuerwerker (2020), there is also a trend in standardizing organizational care arrangements, disregarding local contexts and accumulations. To overcome this vector, it is necessary to move away from bureaucracy and repetition of hegemonic modes of care; go beyond the clinic centered on professional nuclei; recognize that everyone engages in management. The dispute is inherent to living work, and negotiation is necessary to ensure a more collaborative care.

Therefore, our intention is to explore experiences of care management devices manufactured by small municipalities that can serve as lessons in the production of knowledge and practices within SUS.

## Cartography as an ethical-political research approach

The cartographic approach was used as an ethical-political methodological choice, recognizing that knowledge is produced in the encounter between living beings by tracing a wandering and intuitive path through the modes of existence,

knowledge, and practices of the various living actors from SUS (Lima; Merhy, 2016).

For this, it assumes an openness to encounters, permeability and reflection, and presupposes a movement of producing encounters in which one shares reflections, discomfort handling, query production, displacements, as well as the creation of knowledge from all this. It is a collective production in which everyone, not only formal researchers, becomes an investigator and producer of reflections (Moebus; Merhy; Silva, 2016; Mendes, Azevedo, Frutuoso, 2019).

The subject-researcher development occurs during action, in field experimentation, collecting effects and marks that impregnate the body and open the possibility to invent, create, and construct the research path together. In this perspective, implication is the hallmark of knowledge production, and researchers adopt a questioning stance towards themselves and the field in motion, in-worlding themselves in and throughout the territories manufactured by the investigation and interrogating themselves from what emerges through these encounters (Abrahão et al., 2014, 2016).

Moreover, health departments, central or local management spaces, and any health facility are constituted by different levels, crossed by various forces. There is a formal level that defines its purpose, establishes roles, prescribes modes of operation, etc. But this level is crossed by many others. There are political and material conditionings that hinder or facilitate different dynamics and actions. There is a local history; assorted perspectives and projects produced by the different professional corporations, as well as the social movements. There are life stories of each participant, their political, religious convictions. There are the marks left by vocational training. Among many other subjects.

Thus, despite the regularities, there are important differences among different concrete scenarios, resulting from multiple combinations of these and other constituent levels. It is a world in constant production motion, with structural lines, flexible lines, captures, rigidities, and inventions depending on the effects of the different forces configuring it.

Considering, furthermore, that work in health is produced through encounters in which different individuals affect and modify each other, we understand that healthcare is produced "on the fly," in action. How can we deeply research something that is produced in action and whose records are, mostly, only marked on the "bodies", in the ways of being of the participants in the processes?

Cartography allows for live gathering of different scenes/productions/assemblages, and collectively analyzing their effects. Why did things happen this way now, and differently at another moment? Why was it possible to operate collectively here, but not in another moment? What do politics, management, different arrangements, and work styles mobilize, enhance, or annihilate? Hereby, it is possible to map devices, bets, strategies, and disputes, greatly enriching the learning and elaborations from experiences (Gomes; Merhy, 2014; Feuerwerker, 2017).

## Results and discussion: devices that favor care and care management

Throughout this study, it was possible to map out significant devices for care management, driven by the force of health needs. These devices composed the agenda of the management team through the choices and movements that each one created in their actions, both at the municipal and regional levels, as a managing strategy. We mapped different organizational arrangements and devices, allowing reflection on how we are producing care – for the production of life or death.

### The NASF team as a magnifying glass for needs and management

Despite the regularities of the primary healthcare network, the *Núcleo Ampliado de Saúde da Família* (NASF – Extended Family Health Center) team stood out as a dual device, acting as support for management and as matrix support for the intra- and intersectoral network, amplifying possibilities for care management. A rhizomatic support, as proposed by Bertussi (2010, p. 170; our translation), that "does not separate the agencies in management and care production, hence the matrix support arrangements are produced within the management itself in order to operate in both fields."

In one of the studied municipalities, there was a clear organizational arrangement of NASF to build mobilizing encounters, especially with Family Health Teams (FHT). They also gained ground with other departments, such as Education and Social Development. It is interesting to note that there is an intense circulation of professionals in several sectors in small municipalities, both within and outside healthcare, which seems to favor approaching and opening up to other actors to produce partnerships.

Similar to other small municipalities, the NASF team makes a significant difference in expanding care offerings beyond the doctor-centered approach. Among the activities that the team usually performs are: individual care for some cases; shared home visits and care with workers from the FHT and intersectoral teams; prevention, promotion, and rehabilitation groups with the FHT, focused on conducting body practices, assisting pregnant women, caring for chronic pain, caregivers, dealing with smoking, etc.; permanent education for the FHT, based on selected topics and/or cases; coordination between intra- and intersectoral teams and services triggered by more complex cases; actions within the community and participating in municipal councils.

It is fundamental when the NASF is ensured a more flexible work schedule and less captured by the outpatient appointment agenda. This way, they can use Permanent Health Education (PHE) as a guide for their praxis, questioning along with healthcare teams some topics that are crucial to care and deserve a critical and careful look, such as violence-related situations.

PHE can be a powerful tool to inspire reflection within the team, connecting real life scenes in order to foster learning and knowledge production based on what is done, and how things are done. Therefore, it is necessary to support the living space in the professionals' and team's agenda, expanding care possibilities.

The NASF toolbox is built daily, accessing its core, as well as its knowledge and practices field, when facing the surprise of each encounter with users,

workers, and managers. Sometimes it is captured by the medical-hegemonic rationality force, being led by hard-light technologies such as access and care flows, along with protocols, to provide some responses. But, in general, the NASF team operates through light technologies, with a lot of listening and permeability within the network. Ergo, it navigates the intricacies of care production with primary care attention teams and the network driven by triggering situations, which includes mental health cases that mobilize and deterritorialize everyone.

It is evident how mental healthcare triggers various actions in the teams, with NASF playing a leading role in a series of network strategies and in the inclusion of this guideline in the management agenda. Mental health deterritorializes and requires network care.

## NASF and mental health as a trigger for network care

Throughout the numerous network movements triggered by mental health cases, changing the logic of care persisted as a challenge. Medicalization, doctor-centered care, increased use of medications, and moral judgments are current issues on how teams structure care. The network articulation and connection, as well as the profusion of ongoing strategies, were noteworthy, but not always sufficient to overcome the dispute.

Among the powerful strategies carried out, the Yellow September and the *Programa Saúde na Escola* (PSE – School Health Program) were used as devices for approaching students in the state educational network, ranging from adolescents to Youth and Adult Education (YAE), given the increase in suicide attempts by young people in the municipality.

In addition to the daily management performed by the teams, other connections became necessary to expand spaces for listening and conversation about psychic suffering in the diversity of lifestyles. Taking advantage of the month dedicated to Yellow September and the agenda that the NASF team already held permanently in the school through the PSE, meetings were organized in schools which involved community leaders and volunteers linked to youth groups and counseling in partnership with the *Centro de Referência de Assistência Social* (CRAS

– Social Assistance Reference Center). The latter also held roundtable discussions on religious intolerance with parents and members of the school community.

Other strategies were also adopted and mobilized actors from various attention points, the primary healthcare network, the C*entro de Atenção Psicossocial* (CAPS – Center of Psychosocial Attention) II and CAPS Alcohol and Drugs (AD)— both the regional references and the ones located in another municipality—the small hospital in the municipality, and Education and Social Development departments. They encompassed from the most to the least ordinary actions, such as performing shared visits and case discussions, holding Yellow September activities at the state school along with the community, developing a mental health care project by hiring an external professional, resuming matrix support, and discussing the service flow with the CAPS team.

Furthermore, the NASF team drew attention to the urgency to expand and strengthen the *Rede de Atenção Psicossocial* (RAPS - Psychosocial Care Network) in the area, for instance, creating two new CAPS in different small municipalities, taking into account that this specialized service was present only in the medium-sized municipality. Even with this regional reference, the intensity of care for most users was hardly guaranteed due to difficulties in access, time, and commuting, as well as care offerings being restricted to what the service understood as healthy. Without producing escape routes, the primary care network and the NASF became responsible for offering care in the municipality itself, yet still centered on drug prescription and individualized psychotherapy. After all, this is a field in intense dispute.

## Public Prosecutor's Office as network producer

Aiming at complex cases, another strategy was adopted in one of the small municipalities, with the NASF team as one of the connection points. "Network meetings" were held, which operated as another device to favor relationships, cooperation, and a living network.

This agenda was built from cases coming from the Public Prosecutor's Office, urging professionals

to come together in a network for discussion. Later, the practice was instituted through a municipal decree, making one professional from each department responsible for composing the intersectoral committee, with weekly/biweekly meetings. This was a powerful device as it brought the reference teams together to construct a more collaborative care plan with different actors in the network.

A second experience at the intersectoral network meeting as a device for care management, linked to another small municipality, was also triggered by the Public Prosecutor's Office (MP). It is interesting how other sectors outside of healthcare can also act as devices for care management, mobilizing the workers' network against the capture of living work. In this municipality, the MP produced movements in the logic of comprehensive care twice: first, with children and adolescents in institutional care, and second, in response to requests for compulsory and voluntary admission to a regional psychiatric hospital.

As effects of these movements, many of which were orchestrated by the MP, there was a drastic reduction in new requests for institutional care and a reassessment of measures for children and adolescents who were under care, reconsidering possible paths, acknowledging the force that also produces "death."

In the first situation, there was a large number of requests to the CRAS and the municipal guardianship council for foster care, drawing the attention of the MP to the strategies of monitoring and attention that should be carried out with the family before resorting to a measure that should be the last one. Subsequent inquiries demanded a change in practices, leading to the organization of intersectoral network meetings with representatives from Healthcare, Education, and Social Development departments, as well as the guardianship council.

First, a preliminary discussion about the care plan was held, followed by meetings with MP technical assistants for a case-by-case evaluation. Despite the power of the intersectoral meeting in generating some changes, especially driven by the health manager and MP technical assistants, some discourses were still restricted to moral judgments and blaming the family. Hence, there was little visibility for vulnerabilities, racial and social aspects, frequent situations of institutional violence, and lack of access to public policies. There was a significant effort, especially from the Healthcare sector, to expand care offerings and engage with these families, which was mobilized by a manager in her negotiating-constructive masking identity.

Another interesting learning experience stemmed from the efforts to provide professionals in this municipality and negotiations with the Prosecutor's Office to support care projects in CAPS II and the network.

The CAPS team played the role of care organizer and coordinator for these users, producing relationships in the network based on the needs they identified there, especially in the Municipal Emergency Room (MER) with crisis care. The strategy for care management was produced by the mental health teams, the emergency care, and by the health manager, who brought the issue and the caregiving arrangement to the management agenda based on her experience as a worker and local service manager. In addition, there was an interesting partnership in creating a certain visibility for care management based on horizontal doctors, who also supported this visibility in negotiations and mediations with the medical staff and regional reference services.

This experience facilitated closer collaboration with the MP so that, in situations where there were requests for psychiatric hospitalization from other professionals or even family members, the evaluation and management would be primarily conducted by the CAPS II team. This device supported the creation of a care plan within the municipality itself.

On the regional level, significant differences were noticeable: two municipalities of different sizes under the same public prosecutor office, with very different approaches to mental health care—one more inclined towards an asylum model and the other one towards a community-based care. The prosecutor strongly emphasized this difference, highlighting that the smaller municipality, with a lower Human Development Index (HDI) in the region, generated far more network-articulated actions in mental healthcare and in supporting children

and adolescents in institutional care than the neighboring medium-sized municipality. The latter referred most cases to therapeutic communities.

Thus, the smaller municipality radicalized care with light relational technology ,whereas the larger municipality, with a robust budget, invested in asylum-based care(lessness).

### Home care shared between MER and primary care network

The same MER that articulated and sustained possibilities for care in mental health crises also shared with the primary care network the home care of some users, including actions such as placing wound dressings on weekends, after many conflicts and tensions between these two points of care.

The shifts and user signaling were coordinated between the services, with a nurse from the MER playing a leading role in this coordination. Notably, many of these arrangements were possible through partnerships with workers who were open to alternative ways of providing care in the comprehensiveness perspective, amplifying the actions in healthcare and placing light technologies under the spotlight, bringing visibility to the needs.

## Some remarks as a provisional conclusion

Care is a living production that depends on how management and workers engage with territories, users, and their needs. There are ways of managing and building work that favor encounters, which are essential for care.

Despite primary care being the place with greatest care production in small municipalities, family health teams are not the only decisive factor for health production. NASF articulating the network, which goes beyond healthcare, connections with different modalities of specialized service production, permeability to different problems, realities, and needs. Municipalities are the door where needs knock.

In the research field, we meet a pulsating life and many disruptive forces, a broad conversation; in this study, however, we gave visibility to the devices that favored care production in a network. In order to manage care, it is essential to produce devices that favor caregiving arrangements beyond providing services and positions in health facilities.

We are talking about a commitment to the axis of care comprehensiveness, articulating intra and intersectoral teams, provoking a change in how work processes are organized, giving visibility to some triggers that help question the repetitions in caregiving acts.

The arrangement and the management stakes are crucial to place care management on the agenda. The world of work is not at all automatic, it is in full dispute among the living actors, crossed by what has been previously established, by the hegemonic medical force that strongly impacts bodies, and by investments in care(lessness). Hence the devices; hence living work; hence displacements and escapes regarding captures, which are countless and diverse.

## References

ABRAHÃO, A. L. et al. O pesquisador in-mundo e o processo de produção de outras formas de investigação em saúde. In: GOMES, M. P. C.; MERHY, E. E. (Org.) *Pesquisadores IN-MUNDO*: um estudo da produção do acesso e barreira em saúde mental. Porto Alegre: Rede Unida, 2014. p. 133-144.

ABRAHÃO, A. L. et al. O pesquisador in-mundo e o processo de produção de outras formas de investigação em saúde. In: MERHY, E. E. et al (Org.). *Avaliação compartilhada do cuidado em saúde*: surpreendendo o instituído nas redes. Rio de Janeiro: Hexis, 2016. p. 22-30.

BERTUSSI, D. C. *O apoio matricial rizomático e a produção de coletivos na gestão municipal em saúde*. 2010. 234 f. Tese (Doutorado em Clínica Médica) – Faculdade de Medicina, Universidade Federal do Rio de Janeiro, Rio de Janeiro, 2010.

CECÍLIO, L. C. O. Apontamentos teórico-conceituais sobre processos avaliativos considerando as múltiplas dimensões da gestão do cuidado em saúde. *Interface*, Botucatu, v. 15, n. 37, p. 589-599, 2011

DELEUZE, G. *Michel Foucault, filósofo*. Barcelona: Gedisa, 1990.

FEUERWERKER, L. C. M. Pensando avaliação em políticas e na gestão em saúde numa perspectiva cartográfica. In: TANAKA, O.Y.; RIBEIRO, E.L.; ALMEIDA, C.A.L. *Avaliação em saúde*: contribuições para incorporação no cotidiano. Rio de Janeiro: Atheneu, 2017. p. 29-36.

FEUERWERKER, L. C. M. Da atenção básica à atenção primária – do cuidado integral territorializado à focalização médico-centrada no SUS: AMAQ, PMAQ e remuneração por "resultados". In: AKERMAN, M. et al (Org.). *Atenção básica é o caminho! Desmontes, resistências e compromissos. contribuições das universidades brasileiras para a avaliação e pesquisa na APS*: Perspectivas para o cuidado, para avaliação e para pesquisa na APS. São Paulo: Hucitec, 2020. Volume 2.

GOMES, P. C; MERHY, E. E. Uma pesquisa e seus encontros: a fabricação de intercessores e o conhecimento como produção. In: GOMES, P. C; MERHY, E. E. (Org.). *Pesquisadores In-mundo*: um estudo da produção do acesso e barreira em saúde mental. Porto Alegre: Rede Unida, 2014.

GUERRA, D. M. *Descentralização e regionalização da assistência à saúde no estado de São Paulo*: uma análise do índice de dependência. 2015. 209 f. Tese (Doutorado em Ciências) – Faculdade de Saúde Pública, Universidade de São Paulo, São Paulo, 2015.

HENZ, A. O. Políticas de pesquisa entre Anton Tchekhov, narrativas, casos infames. *Verve*, São Paulo, n. 41, p. 73-90, 2022.

LIMA, F.; MERHY, E. E. Produção de conhecimento, ciência nômade e máquinas de guerra: devires ambulantes em uma investigação no campo da saúde coletiva. In: MERHY, E. E. et al. (Org.). *Avaliação compartilhada do cuidado em saúde*: surpreendendo o instituído nas redes. Rio de Janeiro: Hexis, 2016. p. 18-21.

MENDES, R.; AZEVEDO, A. B.; FRUTUOSO, M. F. P. (Org.). *Pesquisar com os pés*: deslocamentos no cuidado e na saúde. São Paulo: Hucitec, 2019.

MERHY, E. E. O conhecer militante do sujeito implicado: o desafio em reconhecê-lo como saber válido. In: FRANCO, T. B.; PERES, M. A. A.; FOSCHIERA, M. M. P.; PANIZZI,M. (Org.). *Acolher Chapecó*: uma experiência de mudança do modelo assistencial, com base no processo de trabalho. São Paulo: Hucitec, 2004.

MERHY, E. E. et al. (Org.). *Avaliação compartilhada do cuidado em saúde*: surpreendendo o instituído nas redes. Rio de Janeiro: Hexis, 2016.

MOEBUS, R. N.; MERHY, E. E.; SILVA, E. O usuário-cidadão como guia: Como pode a onda elevar-se acima da montanha? In: MERHY, E. E. et al (Org.). *Avaliação compartilhada do cuidado em saúde*: surpreendendo o instituído nas redes. Rio de Janeiro: Hexis, 2016. p. 43-53.

PEREIRA, P. B. A. *Arranjos e dispositivos para a gestão do cuidado em municípios de pequeno porte no estado de São Paulo*: entre-laços e nós. 2022. 220 f. Tese (Doutorado em Saúde Pública) – Faculdade de Saúde Pública, Universidade de São Paulo, São Paulo, 2022.