School Health Program: health education challenges for the prevention of Dengue, Zika, and Chikungunya

Programa Saúde na Escola: desafios da educação em saúde para prevenir Dengue, Zika e Chikungunya

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DOI: 10.1590/0103-11042022E313I

ABSTRACT This article reflects on health education strategies for the prevention of Dengue, Zika, and Chikungunya within the School Health Program toward comprehensive health care of students of primary public education in schools, in partnership with the Primary Health Care Units. This national research is nested in a project called Arbocontrol and coordinated by the Faculty of Health Sciences of the University of Brasília, with support from the Ministry of Health, to combat and control arboviruses transmitted by Aedes aegypti. This qualitative study is based on the Foucauldian thinking of biopolitics. One hundred fifty-eight teachers and 117 health professionals from 16 municipalities in the five Brazilian regions were interviewed. The results indicated that the implementation of the PSE does not incorporate community knowledge into the actions. The content-oriented educational model establishes, a priori, what should be addressed, and the fragile intersectoral articulation for the planning of actions has hampered its effectiveness. Health education is still understood as an informative process for self-care, fostered by biopolitical strategies of disciplining the bodies of subjects or establishing their subjectivities for self-care, making them accountable for their health.

KEYWORDS School health services. Health education. Arboviruses. Disease prevention. Health promotion.

RESUMO *Este artigo apresenta reflexões sobre estratégias de educação em saúde para prevenção da Dengue, Zika e Chikungunya no âmbito do Programa Saúde na Escola (PSE), visando à atenção integral à saúde de estudantes do ensino público básico nas escolas, em parceria com as Unidades Básicas de Saúde. Trata-se de uma pesquisa nacional, oriunda de um projeto intitulado Arbocontrol, coordenado pela Faculdade de Ciências da Saúde da Universidade de Brasília, com apoio do Ministério da Saúde, com vistas ao combate e controle das arboviroses decorrentes do Aedes aegypti. De abordagem qualitativa, este estudo fundamenta-se no pensamento foucaultiano de biopolítica. Foram entrevistados 158 professores e 117 profissionais de saúde, de 16 municípios, nas 5 regiões brasileiras. Os resultados indicaram que, na execução do PSE, o saber comunitário não se incorpora nas ações. O modelo educacional conteudista estabelece, a priori, o que deve ser tratado; e a fragilidade na articulação intersetorial para o planejamento das ações tem dificultado sua eficácia. A educação em saúde ainda é entendida como processo informativo para o autocuidado, fomentado por estratégias biopolíticas de disciplinamento dos corpos dos sujeitos ou na constituição de suas subjetividades para o autocuidado, depositando neles a responsabilidade por sua saúde.*

PALAVRAS-CHAVE *Serviços de saúde escolar. Educação em saúde. Arbovírus. Prevenção de doenças. Promoção da saúde.*

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Introduction

The proliferation of breeding sites for the *Aedes aegypti* mosquito the primary transmitting vector of Dengue, Zika, and Chikungunya (DZC), in homes and community spaces, stems from multiple conditioning factors, such as climatic conditions, migration, disorderly urbanization, planning, or poverty. These arboviruses are currently one of the most significant public health problems in the country and globally. In Brazil, Dengue is still the disease with the highest incidence in all Brazilian states. In the last year alone, probable cases increased by 43.5% in the national territory, with 54 severe cases and ten confirmed deaths only in the first month of this year[1].

Such complexity has affected the country for almost two decades with seasonal epidemics. It has led public policies to seek to implement integrated intersectoral actions to prevent and control arboviruses, including those of the School Health Program (PSE). Their actions are theoretically structured in the Health Promotion (HP) model and geared to students from Brazilian public schools through municipal partnerships established between schools and the Primary Family Health Units (UBSF).

The PSE comprises the HP from the viewpoint of full-time education, whose concept encompasses protection, care, and full development of the school community, based on five components: assessment of health conditions; HP and disease prevention; continuing education and training of education and health professionals and youth; monitoring and evaluation of both student's health and the program[2].

By joining the PSE, the municipality must prepare a project – understood as a 'technical reading' of the municipal situation within Education and Health actions – delimiting the territories by area covered by the Family Health Strategy (ESF) teams, presenting information on the situational diagnosis, mapping the Primary Care/Family Health Network in the Unified Health System and Education Networks – state and municipal, also establishing the attributions of the ESF teams and the schools, quantifying the number of schools, students of each establishment, and the priority issues of the profile of these students.

This strategy of articulating joint actions between ESF teams and public schools is based on the assumption that the latter represents a privileged space for disseminating information, building knowledge, and upbringing subjects, thus expanding the reach and impact of actions related to students, their families, and the community.

The HP understands social determinants' importance and role in people's health. Its practices propose articulating technical and widespread knowledge and mobilizing public, private, individual, and collective resources to face health problems[3]. The confluence between Education and Health occurs by meeting these two pieces of knowledge, whose crossing point occurs in the subject's body.

Pedagogical theories and practices that advocated disciplining and training of bodies introduced Education in the Health field through interventionist models grounded on the information-action relationship. From this perspective, health education strategies nowadays still consist of adapting behaviors, implementing habits and attitudes, and teaching health responsibilities, placing the individual as a central point for the desired change process[4].

Based on the philosophical thought of Michel Foucault[5], we aimed to understand how the understandings of health education practices aimed at preventing DZC arboviruses developed in the PSE have been established in the discourses of Education and Health professionals, identifying the program's challenges. In the Foucauldian perspective, discourses systematically form the objects they speak of; that is, they name things but, above all, establish truths and guide behavioral strategies, whereby discursive practices as everything

that can and must be said about a particular context from a specific position and historical moment.

From this theoretical perspective, discursive practices are impregnated with power and knowledge relationships. Such an understanding allows for searching for forms and rationalities of power in the discourses of Education and Health professionals.

The relationships between forms and rationalities of power and the processes of subjectivation of individuals (subjectivation refers to the formation of individuals as governable citizens and the formation of individual existence) were examined by Foucault[6] from the concept of 'Governmentality' – described as the set comprising institutions, procedures, analyses and reflections, calculations and tactics that allow exercising this very specific, albeit very complex, power form targeting the population; as predominant form of knowledge, the political economy; and as an essential technical tool, the security devices – a neologism created by him from the fusion of the words 'govern' and 'mentality', to emphasize the interdependence between government practices – which refers to the instrumental level and encompasses the means by which particular policies are designed and implemented – and the mindsets that underpin such practices; governmentality that allows examining the several and complex ways in which truth is produced in the social, cultural, and political spheres.

On this basis, discourse becomes a vital tool to understand what is accepted, regulated, prohibited, or established as truth in the social sphere, mainly when analyzed in the school setting – considered the ideal locus to significantly influence child-adolescent behavior, knowledge, sense of responsibility, ability to observe, think, and act.

Health education is understood as a process that equips individuals to develop a highly critical view of their living conditions, leading them to seek alternatives to transform it for their benefit and that of their community. This understanding is reflected in the discourse of health education in the school environment, whose central axis is developing transformative learning of attitudes and life habits to encourage reflection on the sense of responsibility for each citizen's individual and collective health.

The understanding of such conceptions is essential when attention is paid to the statements of professionals who work in political strategies, such as the PSE, crossed by laws and decisions, which can produce 'truths' or specific understandings about educational practices in health in this case, intended to the DZC prevention.

Thus, the question is, 'when these professionals talk about health education actions and strategies to prevent arboviruses in schools, which practices do they refer to? Are their practices aligned with the HP model advocated by the PSE?'.

Material and methods

A qualitative, multiple-case approach was adopted to achieve the objectives outlined in this work, analyzing secondary data retrieved from a semi-structured interview held with 158 teachers in 16 municipalities of the five Brazilian regions from 2018 to 2019.

The following inclusion criteria were considered for selecting the sample: municipalities classified as urban and intermediate adjacent and remote, per the Classification and Characterization of Brazilian Rural and Urban Spaces of the Brazilian Institute of Geography and Statistics (IBGE) in 2018; adherence to the PSE; and participation of the Rapid Survey of *Aedes aegypti* Indexes (LIRAa) in 2016 and 2017.

The justification for choosing the type of study (multiple cases) is anchored in the approach of Yin[7], in which the same study can contain more than a single case. The set of cases underpins a multiple-case project, allowing the researcher to focus on a small number of cases and explore the facets of the cases in great detail.

The statements of teachers considered involved only those who had participated in some activity concerning actions to prevent or combat the *Aedes aegypti* mosquito in the PSE. The statements of nursing technicians, nurses, and doctors whose work was linked to PSE actions were analyzed within this same logic.

The analysis of the empirical data presented below was performed from the perspective of knowledge-power established in the relationships between individuals or groups – through laws, programs, or mechanisms – that establish contemporary concepts about the production of healthy lives and the prevention of DZC.

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences, University of Brasília, and was approved under Opinion Nº 3.504.219.

Results and discussion

The Arbocontrol Project interviewed 158 teachers from 52 schools linked to the PSE previously indicated by municipal managers, and 117 health professionals – 31 doctors, 41 nurses, and 45 nursing technicians – in Araguaína (TO), Macapá (AP), Vilhena (RO), Campina Grande (PB), Fortaleza (CE), João Pessoa (PB), Anápolis (GO), Caldas Novas (GO), Planaltina (GO), São Bernardo do Campo (SP), Governador Valadares (MG), Belo Horizonte (MG), Gramado (RS), Cascavel (PR) and Dois Vizinhos (PR), in 2018 and 2019.

For this study, from the total number of teachers interviewed (n=158), the discourse of 14 professionals recently hired or in administrative roles who had not participated or were unable to inform about activities for the prevention of DZC by the PSE in schools were excluded from the analysis. Thus, the statements of 144 teachers were considered.

Concerning the inclusion criteria of health professionals, the statements of 101 professionals were analyzed from the total number of respondents in the Arbocontrol Project (n=117), 26 of whom were doctors, 37 nurses, and 38 nursing technicians. We excluded 16 as they were not directly included in PSE educational actions geared toward preventing DZC.

Finally, although Community Health Workers (ACS) and Endemic Combat Workers (ACE) are essential to control and combat DZC arboviruses, given their notorious performance on this work front, such professionals were not interviewed in this study since they were not summoned by municipal bodies (Municipal Education Secretariats and Municipal Health Secretariats) responsible for articulating the PSE actions, for the PSE educational actions in the visited schools.

PSE governance and its challenges

Foucault[6] argues that the main object of government management is the population. To this end, it needs to act in the subjectivation of individuals and raise in them the understanding that the State or its representatives are holders of a certain truth about the phenomena that affect a territory and individuals. The governance forms originate the production of discourses of truth about and in society and involve knowledge production practices. Therefore, governance refers to the instrumental level of management and how specific policies are designed and practiced.

The Federal Government has been seeking, for some decades, to implement proposals that consider the relationship between health and school through a more participatory approach, involving the school community to discover how popular culture represents health, illness, and ways of caring, thus enabling new meanings in the daily lives of citizens and group experiences.

In 2006, the Ministry of Health's Secretariat for the Management of Work and Education in Health (SGETES/MS) published a document entitled 'Health-Producing Education'[8] to mobilize the educational community to 'build' a school that produces 'health' by strengthening

participatory, democratic ways of thinking and doing health education at school. This proposal understood that if the school community were motivated to discuss the causes and possible solutions for the existing health problems in their lives, one could produce new and innovative knowledge and thus change the reality of the local quality of life.

In order to ratify the Health-Promoting School's proposal, the Ministries of Health and Education published Decree Nº 6.286 the following year, establishing the PSE, whose proposition emphasizes that health education practices must consider group knowledge; in other words, everything that the community knows and can do to produce meaningful learning and informed individuals, who can work in a participatory, reflective and critical way to defend their quality of life[2].

In order to advance in the fight against social vulnerabilities, the PSE reinforces the idea of the school as a privileged space for HP practices and disease prevention and seeks to enhance education and health actions by articulating the school and the health unit. This strategy advocates that health and education professionals should adopt an attitude of empowerment of the primary principles of HP aimed at students and the school community.

In this way, creating a health program at school considering HP places management in the face of challenges beyond the consolidation of partnerships that understand and take ownership of the promotion references and the intrinsic aspects of intersectoriality. Moreover, it is necessary to consider that the learning processes and the act of learning transcend the formal school space and that the education subjects can create innovative strategies to face social issues that need to be heard and considered.

We should mention that the management challenges need to be more detailed and addressed in more depth in this work, considering that the program managers in the municipalities were not an object of research.

Challenges of implementing the PSE from the HP perspective

The issues raised by the HP, such as the importance of considering the General Social Determinants of Health of the population or the involvement of the community and its knowledge to provide or generate new and innovative knowledge to transform the local reality, are still hurdles to be overcome in the PSE.

The PSE provided such principles in its structure. Thus, the municipality should perform a 'technical reading' of health or situational diagnosis to identify priorities and aspects that would need to be resized or qualified within the education and health actions in the territory. To this end, the municipality would prepare a municipal project in which the territories would be delimited per the area covered by the ESF teams, thus defining the set of schools linked to these teams and which would work in the PSE in each territory.

The statements reveal that the school teachers and the health professionals of the ESF teams in each territory involved in the PSE need to be made aware of the establishment of goals or the existence of a specific action plan for the program. In practice, what is observed in schools linked to the PSE is implementing a content educational model to guide the plans that establish, a priori, what should or should not be addressed, thus excluding the HP's theoretical basis guiding the PSE.

The school community is not recognized as a subject of knowledge, and the approaches used do not integrate people's knowledge. This strategy that does not consider the social determinants of health and does not produce new knowledge could be identified in the statements of teachers from the municipalities of the five regions of the country. As an example, one stands out, addressed in São Bernardo do Campo:

> *[...] we deliver to the child [...] pamphlets from the Secretariat about the care they should have. [...] a little piece of paper that has a few boxes to*

> *fill in; for example, if she had a vase with a dish of water in her house and [...] what they should do [...].* (ESC1PROF2; SBCampo).

This health education concept, still inscribed in the perspective of transmitting specialized and standardized knowledge that informs people – whose knowledge is ignored or devalued – and setting which behaviors should be established to avoid illness, is still based on the hygienist perspective of health-related pedagogical practices, whose understanding is that telling people what they should do to be healthy is the same as educating[9].

We should emphasize that the positive bias of such actions was addressed when identifying the aspect of transmitting knowledge in the statements and actions of health education in the PSE. As Foucault explains when referring to pedagogical institutions:

> [...] I fail to see where harm is in the practice of someone who, in a given game of truth, knowing more than another, tells him/her what needs to be done, teaches him/her, transmits knowledge, and communicates to him/her the techniques; the issue is rather to know how one can avoid the effects of domination in these practices – in which power cannot fail to be exercised and is not bad in itself[10](284).

What occurs is the standing idea that health education is an issue that involves only adequate technical-scientific information to be transmitted and made available vertically through the personal or political will of subjects exposed to specific health problems.

The challenge of intersectoriality as a practice in the PSE

Historically, the convergence of Health and Education occurred as a biopolitical strategy to implement (and guarantee) community control actions, such as disease prevention, demographic distribution, and population aging.

When announced as an intersectoral policy, the PSE guidelines indicate that this will be its operationalization, whose implementing responsibility will be shared between Education and Health, and this interaction is its main power. This shows and configures a way of doing education in health, which demands adaptability and flexibility as strategies to streamline different resources.

However, the statement of subjects from schools and health units linked to the program leads us to assume two types of rationalities put into action: one arising from the idea that produced how the PSE was 'thought' or written and that made it cross the HP theoretical scope, therefore, of joint action that considers community knowledge; and another put into operation using a content technique, from the hygienist perspective of intervention, to control and standardize conducts.

If the PSE, in its structure, does not conceive the action of health professionals as specialized knowledge instructors, nor that of educators as one that passively absorbs the guidelines and instructions and passes them on to students and the community, one cannot lose sight that a disciplinary device around knowledge normalizes them and politically establishes a hierarchical relationship between them. It is necessary, therefore, to remember the ways the disciplinary and regulation norm (biopolitics) intersect – and such intersection occurs in the field of practices and knowledge that inform education or in the policies that cross it and manage it for specific strategic ends – produce certain knowledge-power effects and potentiate new forms of governmentality[11].

The statements reflect this normalized and hierarchized knowledge movement, the place of power historically established between these two fields, and the consequent fragility of the collaborative interaction proposed between Education and Health in the implementation and execution of PSE actions in all municipalities studied, as can be seen in the excerpts of the statements, for example, given in Vilhena and Planaltina:

[...] Sometimes we receive [...] health professionals [...] who come to the school [...]. (ESC3PROF6; Vilhena).

[...]. Someone comes [...] talking and sensitizes the community and we [...] continue the project throughout the year inside the classroom. (ESC2PROF2; Planaltina).

In the PSE functioning in the different municipalities, the disciplinary power somehow asserts its effects. While being closed institutions that distribute subjects, the expected effects are at the individual and population levels.

From the biopolitical perspective, the public school is invited to participate to ensure that situations are listed, and community problems are mapped so that the State can know, monitor, better control, and intervene vis-à-vis those who are vulnerable, hence a school increasingly involved with social problems and active in the living conditions of this population.

This government strategy – aimed at socially vulnerable students from public schools –to control risks and spread responsibility over themselves and others requires that everyone is well informed of possible risks and actions to minimize health problems. What is expected from pedagogical devices is that they are used to protect themselves – and prevent themselves – from present and future risks. When associated with the media, the effects of these devices are potentiated as they produce

> images and meanings; in short, the knowledge that somehow addresses the 'education' of people, teaching them ways of being and experiencing the culture in which they live[12].

Therefore, the media not only conveys but, above all, "builds discourses and produces meanings and subjects"[12], as explained in the discourses of teachers when they express:

We went to the health center, asked for pamphlets, and raised awareness on the street [...]. (CEI2PROF2; J. Pessoa).

We work a lot [...] with informative texts [...] to make children aware. [...]. (ESC3PROF2; G. Valadares).

When analyzing the statements of health professionals, only two doctors from Araguaína/TO referred to actions in school/PSE. Regarding nurses, we identified discourses referring to the PSE in all regions. Among the nursing technicians, only one in Macapá/AP referred to it.

It is necessary to reflect on the key HP element, which is participation with a clear understanding of the role of people, groups, and organizations in establishing the objectives. The PSE cannot be effective if it is proposed or implemented by a single sector. It is essential to avoid restricting the PSE to sectoral isolation or meeting specific demands, as identified:

The only action that we did recently that involved the whole team regarding arboviruses [...] was in the PSE program [...] last month when we did the work [...] for a week at Schools [...]. (ENF2; Caldas Novas).

The statements are characterized by the lack of dialogue between Health and Education, and the actions target meeting specific or care demands. What can be observed in the implementation of these strategies in the PSE is that they are established and (re)signified by the subjects through a verticalized interaction of the secretariats to the schools, in which medical and health knowledge is preponderant and guides the strategies geared to the community that is excluded from the democratic process of thinking, planning, proposing, or creating solutions to their problems.

It is noteworthy that the reflexive-critical dimension proposed by the intersectoral action is not considered in the transcribed

statements since the knowledge of the health area is disciplinary, established through formulations, whose informative nature aims to the behavioral change of the subjects and is legitimized and reproduced in formal education, as pointed out by Foucault[13]. According to this understanding, modifying behaviors is necessary since individuals, through their habits and attitudes, are responsible for the diseases affecting them and preserving their health.

The actions that should be established by the Intersectoral Working Group (GTI) recommended in the PSE to plan, and articulate actions between Education and Health are not evidenced in any of the five Brazilian regions[14].

The health education challenge in the PSE

The current health information dissemination to the population is a commitment to democratizing access to information. New Information and Communication Technologies (ICT) constantly create informative products for specific groups to facilitate dialogue between the topic and the public.

Admitting that information and education are essential elements for HP, we should stress that informing does not mean educating. Whereas information refers to the content to be made available and which should guide the decisions of managers and educational referrals, education is the establishment of the meaning of information, determining links between the subjects' way of thinking and daily action[15].

The educational strategies conceived in the PSE structure found in the document called 'Stepwise PSE: weaving paths of intersectoriality' published by the Brazilian Ministry of Health[14] advocates that the work must involve teachers and employees based on the principle of 'what they know' and 'what they can do'. It highlights the need to develop in each stakeholder "the ability to interpret daily life and work to incorporate attitudes or behaviors suitable for improving the quality of life"[14(6)]. Finally, it emphasizes the importance of Health and Education professionals promoting the empowerment of the baseline HP principles in students, teachers, and school staff.

However, we could say that this discourse does not resonate in the strategies adopted to implement the program, identified as 'educational lectures', 'awareness' or 'training' actions established as 'Health Education' actions, whether in the UBS or in schools linked to the PSE, as evidenced in the statements by teachers and health professionals when they shared:

> *The issue of prevention [...] we write a text about it. [...] Like a lecture, [...] we show a short video [...].* (ESC3; PROF1; Lawn).

> *[...] I gave a lecture on combating Dengue at school [...] in the neighborhood where we work and [...] talked about the elimination of breeding sites [...].* (NUR2; Macapá).

The transcripts allow observing the traditional way of presenting and addressing issues related to prevention and HP as a specifically instrumental area in which subjects become tools for developing actions. We note the power-knowledge relationship established between Health and Education professionals, in which the role of 'educator' of nurses and doctors is identified when they express that they will give 'lectures', reinforced by the statements of the teachers who 'seek' the staff from the 'health post' to give lectures.

We should remember that a given established discourse addresses how one governs and is governed. It deals with the relationship between the government of others and self-government, which is because this end is only achieved insofar as the government, through its characteristic power – biopower – inscribes itself on individual bodies, producing subjects, shaping them, guiding them, and affecting their conduct to make them people of a particular type, who reproduce specific

knowledge. In this sense, traditionally, biopower is put into action when developing health educational practices.

Another strategy disseminated by the Health Secretariats is sending posters and folders to UBS and schools to disseminate information. For Education and Health professionals, there is an understanding that information from a 'qualified source' can promote behavioral change or population adherence to self-care practices. This understanding has promoted the vertical elaboration of materials, facilitating the assessment of the adequate community understanding of the topics covered, which may explain the low adherence of subjects to the actions and strategies to be implemented:

> *[...] we have all the information, stickers, folders, posters, banners, [...] and many lectures.* (NUR1; Annapolis).

> *[...] we would distribute... It was so scary, you know, that it would kill. However, it didn't help much. It was only when [...] there was a significant outbreak here that [...] people became highly aware...* (NUR2; Dois Vizinhos).

This biopolitical strategy of using folders, posters, and booklets as the primary approach to encourage subjects and the population to 'consume' self-care knowledge produces '*homo economicus*' that relieves a public health system, making it financially feasible[10]. In this context, information, especially the media, is seen as a powerful 'substance' capable of promoting changes in habits, curing diseases, controlling epidemics, or HP.

Media products reportedly have a formative function by producing meanings. Like the school, they employ techniques to generate self-analytical, self-evaluative subjects who can reflect on their acts and sensations fluidly and broadly.

From this perspective, when it comes to analyzing a pedagogical device, Jorge Larrosa[16], since the last century, has already warned of the importance of paying attention to subjectivation in the subject's pedagogical production:

> [...] the pedagogical production of the subject is no longer analyzed only from the viewpoint of 'objectification' but also fundamentally from the viewpoint of 'subjectivation'. In other words, from the viewpoint of how pedagogical practices represent and mediate some specific relationships of the person with himself[6](54).

Therefore, the modes of subjectivation in the PSE can be understood as production practices developed through the objectification of discourses implemented in the school about how the subject-students should behave and how they should act to keep themselves healthy and not become subjects of risk to themselves, the State, and the community.

Final considerations

Health education keeps structuring itself in the biopolitics of disciplining the subjects' bodies with their rules or in the establishment of individual subjectivities for self-care to adapt or adjust subjects to a specific social 'norm' that places in them the responsibility for their health translated as their need to adopt healthy habits and behaviors.

Suppose governmentality considers government practices that can operate 'at a distance' regarding PSE actions. In that case, it seeks to create places and people who can exercise regulated autonomy through lectures, campaigns, posters, and folders, which establish which behaviors are appropriate, who is and who is not at risk, and how subjects should behave to ensure 'the end' of the threat: the mosquito.

The logic of those who carry out PSE in schools and UBS is still that health education is instead an informative process and that 'lack of health' would be indeed an individual issue circumscribed within non-adherence to acceptable behaviors and hygiene such as

using repellents, not throwing garbage on the floor, turning over, or collecting caps or cups in the environment, not accumulating water in plant pots or the backyard and keeping the domestic environment clean.

Social determinants and community knowledge are not considered in the analysis of health problems and the implementation of prevention and HP actions. Even with the proposals that seek to expand the scope of educational programs, such as the strategies of theaters and walks in the neighborhood with students, the such expansion only occurs with the inclusion of the sociocultural repertoire of the community. It is limited to reproducing technical-scientific content to the cultural universe of those to whom it is intended to teach. Teaching strategies technically informed by specific health needs continue to be used, defining 'correct' behaviors for citizens instead of creating opportunities for critical reflection and dialogue between subjects.

In this sense, if the DZC epidemic is, by definition, collective, its containment is seen as individuals' responsibility in their daily practices and care for the domestic and collective environment. This replicating feature aimed at children and individualized in care is a mark inferred in the actions of teachers and health professionals, which is a practice established by biopower, in the governance of the population insofar as it is exercised on each individual, whose articulation point is the school.

Collaborators

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References

1. Brasil. Ministério da Saúde, Secretaria de Vigilância em Saúde. Monitoramento dos casos de arboviroses urbanas causados por vírus transmitidos pelo mosquito Aedes (dengue, chikungunya e zika), semanas epidemiológicas 1 a 6, 2022. Boletim Epidemiol. 2022 [acesso em 2022 fev 20]; 53(6):3-21. Disponível em: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/boletins/boletins-epidemiologicos/edicoes/2022/boletim-epidemiologico-vol-53-no06/view.

2. Brasil. Decreto nº 6.286, de 5 de dezembro de 2007. Institui o Programa Saúde na Escola – PSE, e dá outras providências. Diário Oficial da União. 5 Dez 2007. [acesso em 2022 fev 20]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2007-2010/2007/decreto/d6286.htm.

3. Buss PM. Promoção da Saúde da Família. Rev Bras Saúde Família. 2002 [acesso em 2022 fev 20]; 2(6):50-63. Disponível em: http://bvsms.saude.gov.br/bvs/is_digital/is_0103/IS23%281%29021.pdf.

4. Sabóia VM. Educação em Saúde: a arte de talhar pedras. Niterói: Intertexto; 2003.

5. Foucault M. A Arqueologia do Saber. 6. ed. Rio de Janeiro: Forense Universitária; 2002.

6. Foucault M. Segurança, Território, População. São Paulo: Martins Fontes; 2008.

7. Yin RK. Estudo de caso: planejamento e métodos. 2. ed. Porto Alegre. Bookman; 2001.

8. Brasil. Ministério da Saúde, Secretaria de Gestão do Trabalho e Educação em Saúde, Departamento de Gestão da Educação em Saúde. A educação que produz saúde. Brasília, DF: MS; 2006.

9. Castiel LD, Vasconcellos-Silva PR. Precariedades do Excesso: informação e comunicação em saúde coletiva. Rio de Janeiro: Fiocruz; 2006.

10. Foucault M. Ética, sexualidade, política. 2. ed. São Paulo: Martins Fontes; 2006.

11. Gadelha S. Biopolítica, governamentalidade e educação: introdução e conexões a partir de Michel Foucault. Belo Horizonte: Autêntica; 2009.

12. Fischer RMB. Trabalhar com Foucault: arqueologia de uma paixão. Belo Horizonte: Autêntica; 2012.

13. Foucault M. Vigiar e Punir. Petrópolis: Vozes; 2002.

14. Brasil. Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Passo a passo PSE: Programa Saúde na Escola: tecendo caminhos da intersetorialidade. Brasília, DF: Ministério da Saúde; 2011.

15. Silva JO. Educação e saúde: palavras e atos. Porto Alegre: Dacasa Editora; 2001.

16. Larrosa J. Tecnologias do eu e educação. In: Silva TT, organizador. O Sujeito da educação: estudos foucaultianos. Petrópolis: Vozes; 1994.

Received on 04/28/2022
Approved on 09/19/2022
Conflicts of interests: non-existent
Financial support: Ministry of Health