Collaborative Management as a Communication And Coordination Strategy For The Unified Health System In A Public Health Disaster

Cogestão Como Estratégia De Comunicação E Articulação Do Sistema Único de Saúde Em Um Desastre De Saúde Pública

Gestión Colaborativa Como Estrategia De Comunicación Y Coordinación Del Sistema Único de Salud En Un Desastre De Salud Pública

RESUMO

Os desastres impõem imensos desafios ao Sistema Único de Saúde (SUS) diante da necessidade de planejar e tomar decisões em cenários complexos que requerem ações articuladas entre os diferentes níveis de atenção. Diante disso, têm-se o objetivo de apresentar a cogestão como prática exitosa para promover a comunicação e articulação do SUS no incêndio da Boate Kiss. Trata-se de um estudo qualitativo-descritivo e exploratório documental. No cenário de crise, houve o atendimento de 577 pessoas e transporte aéreo de 57 pacientes críticos. Posteriormente, 836 pessoas foram agendadas para triagem, sendo realizadas 1.309 consultas e 349 exames. Na Central de Informações, foram registradas 2.053 vítimas, 56 serviços e 93 tipos de atendimentos realizados. Concluiu-se que a cogestão foi capaz de instituir espaços transversais de comunicação, articulação e organização de processos que contribuíram para a mitigação do desastre.
PALAVRAS-CHAVE: Interdisciplinaridade; Educação em Saúde Pública; Equipe de Assistência ao Paciente; Inovação Organizacional; Recuperação em Desastres; Despacho de Emergência de Incêndio.

ABSTRACT

Disasters pose immense challenges to the Unified Health System (SUS) due to the need to plan and make decisions in complex scenarios that require coordinated actions between the different levels of care. In view of this, the objective is to present co-management as a successful practice to promote communication and coordination of the SUS in the Kiss nightclub fire. This is a qualitative-descriptive and exploratory documentary study. In the crisis scenario, 577 people were treated and 57 critical patients were airlifted. Subsequently, 836 people were scheduled for triage, with 1,309 consultations and 349 exams being performed. The Information Center recorded 2,053 victims, 56 services and 93 types of care provided. It was concluded that co-management was able to establish transversal spaces for communication, coordination and organization of processes that contributed to the mitigation of the disaster.
DESCRIPTORS: Interdisciplinarity; Public Health Education; Patient Care Team; Organizational Innovation; Disaster Recovery; Fire Emergency Dispatch.

RESUMEN

Los desastres imponen enormes desafíos al Sistema Único de Salud (SUS) debido a la necesidad de planificar y tomar decisiones en escenarios complejos que requieren acciones articuladas entre los diferentes niveles de atención. En este sentido, el objetivo es presentar la cogestión como una práctica exitosa para promover la comunicación y articulación del SUS durante el incendio de la Boate Kiss. Se trata de un estudio cualitativo-descriptivo y exploratorio documental. En el escenario de crisis, se atendió a 577 personas y se realizó el transporte aéreo de 57 pacientes críticos. Posteriormente, se agendaron 836 personas para triage, realizando 1.309 consultas y 349 exámenes. En la Central de Información, se registraron 2.053 víctimas, 56 servicios y 93 tipos de atenciones realizadas. Se concluyó que la cogestión fue capaz de instituir espacios transversales de comunicación, articulación y organización de procesos que contribuyeron a la mitigación del desastre.
PALABRAS CLAVE: Interdisciplinariedad; Educación en Salud Pública; Equipo de Atención al Paciente; Innovación Organizacional; Recuperación en Desastres; Despacho de Emergencia de Incendio.

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INTRODUCTION

Extreme events such as the collapse of the dams in Brumadinho and Mariana and the flooding that occurred in Rio Grande do Sul (RS) reinforce the need to share mitigation strategies and training professionals to act in these situations in the country. Such calamities are classified as disasters, catastrophes and public health emergencies depending on their magnitude. A disaster is one that produces a serious disruption to the normal functioning of a territory, resulting in the loss of lives, material, economic and environmental resources. In public health, it causes damage and worsens the health conditions of the population, producing a massive demand for care that exceeds local capacity and requires national and international assistance. [1, 2]

These situations require the immediate implementation of preventive, protective and risk-containment measures in order to avoid the collapse of the Unified Health System (SUS). In this sense, they pose major challenges in view of the need to plan and make decisions in complex, highly dynamic scenarios that are distinct from the usual risks of the affected territory. This situation requires a coordinated response between the different levels of health care [3] and, to this end, co-management spaces are essential to promote communication and coordination of the care network.

Co-management is characterized by a way of managing that includes collective thinking and action, seeking to democratize relationships in health. It means the inclusion of new subjects in management, in an interdisciplinary, communicative, critical-reflective and pedagogical exercise that promotes the qualification of professionals to work in the SUS. [4] It therefore plays a prominent role in disasters that require systemic planning, based on a broad view of the population's needs and dialogue between health services. This was the objective of an unprecedented co-management experience that took place in the public health disaster that occurred in the city of Santa Maria in RS. This event was classified as the 2nd largest fire in terms of number of victims in Brazil [5] and 3rd biggest nightclub disaster in the world. [6]

In the early hours of January 27th , 2013, a fire caused by a pyrotechnic device at the Kiss nightclub resulted in 242 deaths and 1,222 cases of carbon monoxide and hydrogen cyanide (HCN) poisoning. [7, 8] HCN is a highly volatile and toxic liquid or gaseous chemical agent that can be absorbed orally, nasally and through the skin [9], causing mental confusion, severe metabolic acidosis, hypotension, sei-

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zures, cardiac dysrhythmias and coma. [10] Such exposure generated a high demand for urgent and emergency care that quickly exceeded municipal capacity. [7]

To intervene in this emergency scenario, the work carried out by the National SUS Force (FN-SUS) was essential. [4] This being a cooperation program that implements prevention, assistance and response actions for public health emergencies of national importance. It operates from the perspective of co-management to increase response capacity in the face of exhaustion of local resources. [11]

In addition to the FN-SUS, a local-regional co-management strategy called the "Care Management Group" was established, which was composed of managers, health professionals, social control and users. This management committee aimed to guarantee longitudinal care for fire victims and manage assistance actions in a shared manner. In view of this, this report aims to present co-management as a successful practice to promote communication and coordination of the SUS in a public health disaster.

METHOD

This is a report based on a retrospective, qualitative-descriptive and exploratory documentary study that covered the period from January 27, 2013 to January 1, 2015. The research subjects were the most assiduous members of the Care Management Group: two regional managers, one federal manager, two municipal managers, four health professionals and a representative of the Association of Relatives of Victims and Survivors of the Santa Maria Tragedy (AVTSM). The study was approved by the ethics committee (Opinion No. 555,053).

The research used two approach techniques: semi-structured interviews and participant observation. Initially, the subjects were interviewed individually, using a semi-structured questionnaire with thirteen questions: eight questioned the institution's process, operational dynamics and objective of the management board and five sought to evaluate the group itself, its results and continuity challenges. Afterwards, a pedagogical workshop was held to collectively discuss the answers. Finally, an exploratory documentary analysis was carried out in government records and websites.

RESULTS

Numerous civil and public actions sought to mitigate the damage caused by the disaster. This report will focus on those initiated by FN-SUS and the Management Group, as co-management strategies. The actions will be presented in four time periods:

I) Crisis or Emergency Phase (72 hours);
II) Post-Critical or Hospital Phase (90 days);
III) Outpatient Phase (12 months);
IV) Recovery or Post-disaster Phase (5 years).

I - Emergency Phase

This was the period immediately after the fire. In this scenario, the FN-SUS set up the "Crisis Office" to operationalize the removal of critical patients to Porto Alegre. 57 victims with severe burns were transported by the Brazilian Air Force (FAB) and of these, 49 required mechanical ventilation (MV) [12] (Figure 1).

Figure 1: Transport of patients using FAB helicopter and plane.

Source: BRAZIL. Ministério da Saúde. Relatório apresentado ao Grupo Gestor do Cuidado na Reunião de avaliação das ações em prol das vítimas do incêndio, no Hospital Universitário de Santa Maria. Santa Maria, 2013.

In the first hours after the fire, 577 victims were treated in Santa Maria, of which 117 were hospitalized and 35 used MV 13. To provide assistance, the Ministry of Health (MS) made available two ambulances, 30 pulse oximeters, 52 mechanical ventilators, 15 multiparameter monitors, 67 FN-SUS professionals, 10 fiberoptic bronchoscopy specialists, 120 mental health professionals and numerous medications. The average number of critical patients discharged from hospital was 98.7%. [13]

International aid was provided through the coordination of FN-SUS with agencies in the United States to obtain 140 units of Cyanokit®. This medicine is used as an antidote for cyanide and, at the time of the fire, was not available in the country and was not registered with the National Health Surveillance Agency (ANVISA). [7] After the end of the emergency phase, FN-SUS professionals returned to their places of origin, requiring a reconfiguration of local-regional management to continue assistance actions.

II - Hospital Phase

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This period was marked by the need to expand hospital capacity and the exhaustion of specialized resources. The first action to overcome this was the publication of Ordinances 677 and 700 of 2013, which made R$1,652,480 reais available for improving hospital infrastructure and hiring 34 health professionals to provide care at the Integrated Center for Accident Victim Care (CIAVA). [14]

Table 1: Commitment Term for continued health care for victims.

Ministry of Health

MINISTER'S OFFICE
COMMITMENT EXTRACT

TYPE: Term of Commitment entered into by the Ministry of Health, the State Secretariat of Health of Rio Grande do Sul, the Municipal Health Secretariat of Porto Alegre, the Health and Administrative Modernization Secretariats of the Municipality of Santa Maria, and the Federal University of Santa Maria.
PURPOSE: To establish cooperation between the signatory entities aimed at carrying out technical and operational procedures to ensure the continued healthcare for the victims, their families, and health professionals involved in the incident that occurred on January 27th, 2013, at the Kiss Nightclub, in the Municipality of Santa Maria (RS), encompassing health surveillance actions, basic healthcare, specialized, and psychosocial care.
VALIDITY: 5 (five) years
SIGNING DATE: February 22nd, 2013

Fonte: Adapted fom BRAZIL. Ministry of Health. Report presented to the Care Management Group at the meeting to assess actions in favor of victims of the fire at the Santa Maria University Hospital. Santa Maria, 2013.

When the first hospital discharges began, many survivors went to the state pharmacy with medical prescriptions, requesting the immediate dispensing of several medications. This generated an exceptional demand, as the service does not have the legal support or technical equipment to operate under these conditions. However, taking advantage of the Emergency Decree, medications from administrative processes were dispensed on an emergency basis. From this, treatment adherence was monitored, which allowed the construction of an online tool for monitoring and actively searching for patients. [15]

In order to prevent new problems from occurring, the Office of the Minister of Health published a Commitment Statement valid for five years (Table 1) to respond to the need for local-regional co-management. This allowed the creation of the Care Management Group, bringing together public institutions, health professionals, social actors and victims of the fire. In record time, the Management Group organized care campaigns to triage the needs of victims. The event was widely publicized in the media. Appointments were made through FormSUS on the Ministry of Health website (Figure 2); by calling the SUS Ombudsman's Office on 136; by active search and by spontaneous demand. [16]

Figure 2: Registration for assistance from the 1st Joint Task Forces in Santa Maria.

Source: http://portalsaude.saude.gov.br/portal-saude/

In total, 836 individuals were registered in FormSUS. Of these, 405 attended the campaigns, during which 349 exams and 1,309 consultations were performed with 11 specialties (Table 1). Most of the consultations were in pulmonology (n=249), followed by physiotherapy (n=206) and neurology (n=105). One hundred and forty professionals and students worked voluntarily. [16] The registrations and services allowed the mapping of demands and the planning of actions necessary for longitudinal care.

Table 1: Services and procedures carried out in the community outreach in Santa Maria.

Actions carried out		1st Joint Task Force	2nd Joint Task Force	TOTAL
Appointments	*Reception / Screening*	*271*	*134*	*405*
	Pneumology	*159*	*90*	*249*
	Neurology	*73*	*32*	*105*
	Ophthalmology	*14*	*0*	*14*
	Physiotherapy	*111*	*95*	*206*
	Otorhinolaryngology	*34*	*13*	*47*
	Nursing/GELP- Burnts*	*14*	*7*	*21*
	Speech Therapy	*46*	*20*	*66*
	Pharmaceutical Assistance	*71*	*11*	*82*
	Psychiatric Emergency	*1*	*16*	*17*
	Occupational Health	*23*	*18*	*41*
	Psychosocial Care	*56*	*0*	*56*

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Total Appointments		873	436	1.309
Tests	*Imaging tests*	*24*	*75*	*99*
	Laboratory tests	*22*	*13*	*35*
	Spirometry/Oscillometry	*62*	*70*	*132*
	Walking Test	*26*	*35*	*61*
	Electromyography	*16*	*6*	*22*
Total Tets		*150*	*199*	*349*
TOTAL		*1.023*	*635*	*1.658*

Source: BRAZIL. Ministry of Health. Services and procedures carried out in the community outreach in SM. 2013.
Note: GELP (Skin Lesion Study Group - Grupo de Estudos em Lesão de Pele).

III – Ambulatory Phase

This period was marked by the need to establish a transition in care and define referral and counter-referral flows. Numerous services monitored patients and there was difficulty in accessing and sharing updated information that was essential to coordinating the care network. The breadth of specialties and levels of care involved in care contributed to this; however, the real reason was the lack of an integrated electronic medical record in the SUS.

To overcome this problem, a spreadsheet was created in Microsoft Excel® and shared online via Google Drive®. A simple, fast, practical and cost-free solution that allowed information to be updated in real time between the different points of care. There was no need to train professionals to use the tool, which allowed its immediate incorporation.

Still on the subject of communication, patients and family members constantly requested more information about outpatient care and medications available through the SUS. This information was made available on the AVTSM website and, in addition, an interface was created for typing questions about the use of medications in the "Survivor's Space" of this website. The message was sent to the email of a pharmacist from the Management Group and the response was returned to the email of the requesting person. [7]

Access to medication was a recurring issue throughout the outpatient phase. In this regard, the Management Group worked on drafting CIB-RS Resolution 646 of 2013, which enabled the purchase and dispensing of medications not incorporated into the SUS for the treatment of skin (sunscreen and moisturizer) and respiratory problems (including: salmeterol/fluticasone, N-acetylcysteine, fluticasone, indacaterol and ciclesonide). [7] In 18 months, 350 medications were made available to 88 survivors. [14]

IV - Post-Disaster Phase

This period was characterized by inter-institutional actions involving education, health, justice and human rights. Several strategies were articulated in order to structure the municipal scenario to experience the date of the first year after the fire. Meetings were held at universities, welcoming of new students, psychosocial support actions and recreational activities on mourning in municipal and state schools. All actions converged on January 27, 2014, when the Management Group and FN-SUS participated in the International Congress New Paths - Life in Transformation of AVTSM.

Sixteen months after the fire, a member of the Management Group was appointed coordinator of the "State Program for Damage Reduction (PERD - Programa Estadual de Redução de Danos)", linked to the Department of Justice and Human Rights, with the aim of expanding the monitoring actions for victims of the Kiss Nightclub. This initiative was developed by the Information Center (Figure 2) together with the Information and Communication Technology Center of RS (PROCERGS). The goal was to create a system that would allow the recording of the therapeutic itinerary and clinical data for longitudinal care. Thus, the Information Center intended to replace the online spreadsheet shared between services and contribute to the resolution of cases by the SUS. [8]

Figure 2: Information system developed by the State Harm Reduction Program.

Source: GOVERNMENT OF RIO GRANDE DO SUL. Secretariat of Justice and Human Rights. Project for the implementation of the State Harm Reduction Program. Porto Alegre, 2014

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The Information Center allowed the registration of 2,053 direct and indirect victims, based on records from FormSUS and the Notifiable Diseases Information System (SINAN).16 A total of 1,697 records were identified (82.66% of the total). The majority were direct victims, with 485 survivors and 242 fatal victims. Regarding indirect victims, 312 were family members; 355 were people with various involvements in the disaster (94 had emotional relationships with fatal victims; 190 worked at the fire site and 19 were professionals involved in the rescue). [8] Unfortunately, it was not possible to complete the identification, as the change in state government after the elections resulted in the deactivation of PERD and the Information Center.

DISCUSSION

For co-management to be successful in mitigating the disaster that occurred at the Kiss nightclub, numerous actions were needed to integrate the healthcare network, and a key aspect of this was communication, access and sharing of information. This was possible due to the establishment of mechanisms that allowed effective communication between the different health services and stakeholders, and that could also be extended to managers in the areas of justice and human rights, users and social control.

In this scenario, it is worth highlighting the importance of systematizing data collection and analysis for the dissemination of information. [17] To achieve this, a robust and integrated information system is essential. It is rare to find experiences that were able to develop their own resource, tailored to their needs, such as the Information Center described here. While this represented a step forward in mitigating the disaster, it also revealed a persistent weakness in communication, registration, access and sharing of information in public health in the country.

Another extremely important point is the coordination of different levels of care, and this requires qualified human resources. [17] Therefore, it is necessary to structure professional training programs that qualify these actors for strategic management in all phases of disaster mitigation, preparing them to work in an interdisciplinary manner; in order to prevent risks, organize responses, rehabilitate living conditions and rebuild the community. [3]

In the SM disaster, co-management was a local-regional strategy for professional qualification when it organized mediation spaces with actors from the National Humanization Policy, Doctors Without Borders, professional firefighters, consultants, civilian volunteers, among others. [13] However, for there to be an adaptive response from the SUS in other calamitous events, there must be permanent national strategies for the training of specialized human resources with expertise in disasters and public management.

From a political-democratic perspective, co-management allowed the establishment of effective mechanisms for negotiation, definition of priorities, organization of processes and management of unforeseen events that were capable of influencing policies and mobilizing resources for the execution of agreed actions. To a large extent, transversality contributed to this achievement. From its perspective, the different public entities can talk to the experience of the people and territories that require care. Together, this knowledge can produce health in a co-responsible manner. [18, 19] This approach ensured that decisions were guided by the needs of the population, contributing to more responsive management adapted to the local scenario.

Conducting innovative and unprecedented complex longitudinal care actions - given that there was no information on the outcomes of cyanide exposure - was only possible due to the multiplicity of actions and knowledge. It was essential to have managers from all spheres of the SUS, professionals, patients and social actors composing these co-management spaces. This unique configuration, marked by maturity and the learning accumulated throughout the process, stood out as an example of collective and adaptive construction, reaffirming the importance of transversality in the production of health, especially in a disaster situation.

CONCLUSION

The actions described as successful outcomes in the Kiss Nightclub disaster were triggered by two co-management arrangements: the FN-SUS and the Care Management Group. Both reinforced the central role that public health plays in mitigating damage in disasters, operating through different sectors at different times. To this end, integrated actions were articulated that defined clear attributions through effective communication that was only possible through the creation of specific mechanisms to overcome the operational challenges of the SUS. This enabled cross-cutting practices and the qualification of professionals in all spheres of management. Conceived in this way, co-management provided an opportunity for a plurality of perspectives, which minimized blind spots and strengthened ties between the different actors, enabling joint responsibility for actions and their results.

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REFERENCES

1. ORGANIZACIÓN PANAMERICANA DE LA SALUD. Logistica y gestión de suministros humanitarios en el sector salud. Humanitarian supply management in logistics in the health sector (2001).

2.Cerutti, D. F. & Oliveira, M. L. C. Aplicação da gestão de risco de desastres no Sistema Único de Saúde (SUS). Cad. Saúde Colet. 19, 417–24 (2011).

3.Silva, M. A. D., Xavier, D. R. & Rocha, V. Do global ao local: desafios para redução de riscos à saúde relacionados com mudanças climáticas, desastre e Emergências em Saúde Pública. Saúde Em Debate 44, 48–68 (2020).

4.Reinheimer, I. C. Uma situação de desastre, um colegiado gestor e os desafios para garantir o cuidado longitudinal em saúde. Residência Multiprofissional Integrada em Sistema Público de Saúde [trabalho de conclusão de curso]. Universidade Federal de Santa Maria: Manancial - Repositório Digital da UFSM. Santa Maria; 2014. Disponível em: https://repositorio.ufsm.br/handle/1/754

5.Exame: Os maiores incêndios do Brasil antes de Santa Maria. [internet]. 2013. [acessado em 2024 mar 29]. Disponível em: bit.ly/3xf3gAR

6.BBC Brasil: Tragédia em boate de Santa Maria é 'terceira mais fatal da história'. [internet]. 2013. [acessado em 2024 mar 29]. Disponível em: bbc.in/4aDP17f.

7. Andrade CS, Reinheimer IC, Noal MC. Protocolo de Assistência Farmacêutica. In: Protocolos de atendimento às vítimas da Boate Kiss. Adriane Schmidt Pasqualoto...[et al.], (organizadores), Santa Maria: Ed. UFSM; 2016. p. 177-204.

8. RIO GRANDE DO SUL & Secretaria de Estado da Saúde do Rio Grande do Sul. Portaria no 506, de 02 de julho de 2014. Diário Of. (2014).

9.PubChem: Hydrogen Cyanide. [internet]. 2024. [acessado em 2024 mar 29]. Disponível em: bit.ly/3xl4V8g

10. Desai, S. & Su, M. K. Cyanide poisoning. Uptodate. [internet]. 2023 [acessado em 2024 mar 29]. Disponível em: bit.ly/3VzhmHv

11. BRASIL. Ministério da Saúde. Força Nacional do SUS. Site bit.ly/3PEzpbx.

12. BRASIL. Conselho Nacional de Secretários de Saúde. Tragédia em Santa Maria – MS continua apoiando as vítimas e familiares. CONASS [internet]. 2014. [acessado em 2024 mar 29]. Disponível em: bit.ly/43D87rO

13. BRASIL. Ministério da Saúde. Relatório apresentado ao Grupo Gestor do Cuidado na Reunião de avaliação das ações em prol das vítimas do incêndio, no Hospital Universitário de Santa Maria (2013).

14. O papel do CIAVA no atendimento às vítimas da Kiss. Empresa Brasileira de Serviços Hospitalares [internet] 2015. [acessado em 2024 mar 29]. Disponível em: bit.ly/3xopr7G.

15. BRASIL. Ministério Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização. Gestão Participativa e Cogestão (2009).

16. RIO GRANDE DO SUL. Estruturação da Vigilância Epidemiológica em Situação de Emergência em Saúde Pública decorrente de Incêndio em Boate no Município de Santa Maria, RS. Bol. Epidemiológico, v. 16, n. 1, Março de 2014 [Internet]. 16 p. [acessado em 2024 mar 29]. Disponível em: https://docs.bvsalud.org/biblioref/2020/11/1129669/v-16-n-1-mar-2014-pag-1-3-ses-rs_1.pdf

17. Okumoto, O., Brito, S. M. F. & Garcia, L. P. A Política Nacional de Vigilância em Saúde. Epidemiol. E Serviços Saúde 27, (2018).

18. Mendes, E. V. As redes de atenção à saúde: revisão bibliográfica, fundamentos, conceito e elementos constitutivos. In: As redes de atenção à saúde. Brasília: Organização Pan-Americana da Saúde, 2011. p. 61-208.

19. Mendes, E. V. As mudanças na atenção à saúde e a gestão da clínica. In: As redes de atenção à saúde. Brasília: Organização Pan-Americana da Saúde, 2011. p. 293-438.

DOI: https://doi.org/10.36489/saudecoletiva.2025v15i92p14011-14017