

Promoting and recovering health: meanings produced in community groups within the family health program context*

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ABSTRACT

Public Healthcare in Brazil has tended to reflect major changes in the healthcare model. New tendencies point to the importance of actions being built up from their context and focused on specific communities. The objective of this study is to describe the meanings of health / illness as produced by community groups within the context of a Family Healthcare Program. Five groups had their single-session discussions taped and recorded, under the coordination of the first author. This material was transcribed and, coupled with field notes, formed the database for this study. The analysis described the meanings of the ideas on which new healthcare proposals are being based, providing visibility for the multiplicity of meanings and denaturalizing fixed lines of discourse on healthcare / illness. The final thoughts, developed from the point of view of social constructionism, indicate that healthcare practices based on the process of constant conversation and negotiation between all the social actors involved is a fertile ground.

KEY WORDS: family healthcare; community health services; social constructionism.

Introduction

Since the beginning of the twenty century, when the Public Health in Brazil was configured as a national health policy, sanitary policies have been systemized in the attempt to establish efficient care to the collective (Nunes, 2000). The creation and regulation of the SUS (Unified Healthcare System) are the main milestones of this process. After successive movements and attempts, the SUS was the first legitimate tool assured by law, for the construction of a dignified, humane and universal health system. Since its legal conquest in 1990 (Brasil, 1990) a profound reorganization has been implemented aiming to make operational the already established guidelines and principles to its fully functioning.

The Family Health Program (PSF) implemented in 1994 (Brasil 1994), is part of the system reorganization and is characterized as a strategy to provide progressive health care in the

* Elaborated from the Camargo-Borges (2002) study, research funded by CNPq.

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SUS, attending in the primary health care level and also articulating with other levels of care, towards the construction of an integrated health system. Among its proposals in agreement with the SUS, the PSF is composed by an interdisciplinary team which acts in a specific territory and focus on: the family, the individual integrality, the articulation between the service sectors and active participation of the community (Brasil, 1997).

Thus, the PSF aims to contribute to the reorientation of health care practices, breaking up with the traditional assistance model that prevailed in our society: excludible, focused on the disease, individualized and segmented. Since the intervention is given at the primary healthcare level, the program functions locally and close to the families. The welcoming and the bond are privileged and are characterized as a type of intervention focused on the user, in agreement with the SUS proposal, in order to establish an interpersonal relationship closer to the user's demands. In this perspective, health is taken in a complex process involving multiple factors that may either favor or impede a healthy state. Therefore, the emphasis given to the assistance is based on the proposal of a less technical work that favors proximity to the community.

In this sense, some authors have emphasized the importance of research on health/illness processes, implying that the understanding of what is done in this process permeates the whole organization of the health practice and the users' relation with the health system, their beliefs, ways of action and adherence to the health care treatments. Minayo (1998), for instance, points that when proposing a health action to a certain population is important to be attentive to the values and beliefs shared by this specific group. Oliveira (1998) also discusses the importance of the health conceptions held by a community. According to the author, this understanding underlines the way people face health and how they deal with the disease, which in turn, reflects on their adherence to the treatment and on the trustiness they have in the professional assisting them. The efficacy of a work in a community, or with a specific family, depends on the meaning this work has to them, depends on being something they seek and believe as essential for their lives. Therefore, it is important to understand the meanings this community/family holds regarding health/illness situations in the daily life. We understand that such emphasis in the study of the health/illness processes implies the questioning of universal and fixed conceptions about them, inviting us to focus on the local peculiarities of these conceptions, which may favor more contextualized actions, valuing the assisted population's perceptions and experiences, and helping to critically reflect about which perspective bases a certain health action (Tarride, 1998).

Objective

This study aims to contribute with the discourse about the need to act in health based on the local, democratic and close-to-the-population practices aiming to describe meanings of health/illness produced in community groups in the context of a Family Health Program.

Method

This study was theoretically and methodologically based on the social constructionism theory (Gergen, 1985,1997; Shotter, 1993). This perspective comprehends that the meanings people hold about themselves and about the world are produced from the interaction between people situated in historical specific contexts and supported by local processes of negotiation of meanings, whether consensus or dispute, in their daily practices. Thus, the health care is seen as a social practice inside a historical and cultural context, whose meanings are constantly (re) constructed by interactions between professionals and community, immersed in more ample universes of meanings already available, i.e. general health policies.

Regarding the production of knowledge, the social constructionist perspective also comprehends the research activity itself as a social practice (Spink, 1999) which actively constructs meanings about the object of study. This implies conceiving the methodological design not as an assurance of accessing facts as they really are, but as a social construction that produces versions of the world, “it can have higher or lower power of performance depending on the context of production, historical moment, the social relations in which this production occurs, coupled with the intentionality of that who produces it and the level of conformity of that who receives it” (Spink & Medrado, 1999, p.61). Thus, this study was designed aiming to favor an approximation of the daily life of a target community of a PSF with a scope area of 1300 families of a medium class neighborhood, of a large city in the interior of the state of São Paulo, Brazil.

A total of five community groups were composed, gathering residents of the same street in five different streets. These residents were chosen by geographic criterion in the scope of the Program. The groups attended only a session, which took one hour and fifteen minutes, with about five to nine participants each one. Despite the invitation to participate was extended to the whole family, the groups were composed only by women (average age 50 years old). The groups were very heterogeneous regarding the socio-demographic characteristics (married, single, divorced; from illiterate to college students; with domestic activities and/or low qualified autonomous and with long term employment). Hence, the composition of the groups was based on the participants availability, considering the geographic criterion and the family invitation, after free and informed consent (Conep, 1998) approved by a Ethics in Research Committee.

The groups were coordinated by the first author who introduced the three themes: what means to be healthy, what means to be ill, what self-care means. The group conduction consisted in facilitating the conversations, in pointing issues considered relevant to the topic, keeping the discussions focused and, when necessary, providing guidance regarding doubts about the PSF. The data collection procedure consisted in audio recording these five groups' talks and in taking field notes along one year of contact with this Program. After the

transcription of all the groups sessions, a pre-analysis was initiated which consisted of successive readings of transcriptions and notations, which allowed to elaborate a narrative of each group containing a general description about the context, the main themes discussed, the pattern of group interaction, the affective tone, as well as the managing of the coordinator (Camargo-Borges, 2002).

The analysis itself involved: (1) extensive contact with the transcript texts in order to follow the flow of conversations in each proposed theme, which permitted the construction of similarities between the groups, as well as the specificities of each. From this process, (2) the attention was focused on two distinct forms of conversations: one, in which the participants talked from the perspective of healthy people; and the other, in which people talked as sick people who needed specific care. In the first case, the themes generally involved health conceptions related to the discourses of health promotion, and in the second case, the issues involved access, complaints and dissatisfactions regarding the health system. This observation allowed (3) the construction of two thematic axes, “when the issue is to promote health” and “when the issue is to recover health”, around which the analysis process was built. After these two axes were defined, (4) specific fragments of each group were selected, chosen by their relevance in evidencing the multiple meanings that evolve around the health/illness process among the participants in these conversations. The descriptive analysis of these fragments (fictitious names) is presented as follows.

When the issue is to promote health

The analysis of the first axis involved moments in which participants talked about how to have quality of life; what is necessary to do in order to keep a good health and well being; what they consider to be sick and how they deal with it. In short, how they treated these issues in their daily lives. These talks raised themes we associated with meanings refereed in the discourses about health promotion in many contexts (professional, academic, media in general). What really caught our attention, and was the main object of our analysis, were the unfolding of these themes in the conversations – what meanings were produced regarding to what to promote health is? We selected these moments of conversation with fragments of reports of the group participants themselves, developed in three themes: (1) “having problems reflects on your health”, “I think that being ok with life is everything” and (3) “if you aren’t healthy, you can’t work.”

The first of them, “having problems reflects on your health” refers to moments of conversation in which health was described as a sum of several factors that move the human being: physical, mental, emotional and social. In the example bellow, Mercedes, participant of one of the groups, gives her opinion about what she considers being healthy:

Mercedes: It is the physical, mental and emotional welfare, isn't it? And therefore the social.

Melissa: Right, I consider this as health, everything is together, isn't it? A couple of things. Because you can be healthy but... be healthy and having problems reflects on your health (...) Not just the physical health, because the physical we have, but it is also the mental, which I also think of as illness, when you are not well mentally.

In this talk, the participants focused on several aspects involved in the integral health issue. In a tuned bio-psycho-social discourse, they talked about the importance of the physical, mental, emotional and social well being. In the development of these talks, such aspects were described as having a separated existence, each segment reflecting upon the other, forming a "set of important things", though independents, being necessary to join the separated parts in order to have integral health.

The second theme, "I think that being ok with life is everything" approaches the moments in conversation in which the participants reported good life habits as providers of a good health. To promote health means being ok with life and having good habits, these contribute to being healthy.

In one of the groups, talking about nutritious aliments as an important source of health, the participants exchange tips of foods:

Inês: Eat a banana everyday in the morning

Laura: An Apple...

Nilda: Cauliflower...

Laura: Papaya, papaya is good... (...)

Milena: I'm having mustard these days. Wow, you should see how good it is for intestine. Wonderful.

Celiane: Mustard? (...)

Laura: You can make a juice out of the beetroot's water. Good for anemia.

Celiane: Yes, it is good.

Laura: Yes... it is... medicine for bronchitis You take the water out of the beetroot put it in the mixer, put sugar and use it as honey.

This talk initiates with the association of a good eating habit to promote health and good quality of life. The foods each one considers to be important for health are cited. However, in the development of the conversation, the meanings more associated with health promotion, are produced in agreement with the medical discourse. The food is refereed to as a remedy, associated to a certain pathology and not with a daily source of nutrition and health.

The third theme "“if you aren't healthy, you can't work” refers to moments in conversation in which the employment/unemployment was directed connected to the health/illness process, associating health with being strong to work, while being sick leads to unemployment.

In the example bellow, the group was discussing about being sick and its consequences:

Celiane: And for Mrs Meire and Meila, what is it to be ill?

Meire: I have somebody at home unemployed. Today he is starting a job. He can not find anything (...) and also he has problems with his pressure. He falls, he passes out.

Milena: Mrs Meire, if he passes out, feels dizzy... how can he work?

Meire: He can not. The guy already told him that he can not work up the pole. And if he has those... he will die.

In this conversation, health was linked to work since it is necessary to be healthy and strong in order to perform a job and consequently, to obtain one's maintenance. Being sick would be in the extreme opposite, the incapacity of performing a job, which consequently leads to unemployment – being unemployed as a consequence of being sick. The development of this conversation is based on a logic which is inverse to that found in the discourses of worker's health promotion, reported both in national and international conferences, in which unemployment generates social exclusion, compromising people's citizenship in their rights and therefore, characterized as a social disease. For the participants, health generates employment and disease unemployment in a very concrete way in regard to their daily lives.

In the construction of this first axis of the analysis “when the issue is to promote health” we extracted fragments of group conversations which we believed referred to many of the conceptions present in the more current discourses regarding health promotion. In addition, others fragments were extracted in which these meanings were associated with a care focused on the disease. We sought, therefore, to give visibility to the multiple meanings that are constructed on the issue of recovery of health as the talks were developed.

When the issue is to recover a healthy state

In the second axis of the analysis we privileged talks that refer to issues of self-care, focusing on moments in which the participants, in the perspective of frail and sick people, talked about several possibilities of care regarding the disease and recovery. In the unfolding talks, the complaints and dissatisfactions regarding the health system appear as they start to report several difficulties in the process of self care and being cared. This axis was composed of three themes, which we named as: (1) “she is healthy, she even has the card of the health center”, (2) “you think I took the medication the doctor prescribed?”, (3) “what we understand by health and what the doctor understands by it”.

We included in the first theme “she is healthy, she even has the card of the health center” fragments of the conversation in which the participants discuss the self care issue regarding the possibility of access to the health services. Being healthy, in these moments of fragility, was linked to the access to the necessary structures in order to obtain recovery. The example follows:

Celiane: This progress that Luciana [daughter] is making, could it be related to health? [referring to a previous conversation about the good progress her daughter is making at school and at home]

Lucélia: Yes. She is healthy, she also has the card of the Health Center. I'm not saying bad things about the Health Center because, when she was born, I had her with the pediatricist. She was a nice person. I have nothing to say about her. It is Doctor Elena and Doctor Tatiane. They follow the girl up.

In this example, Lucélia, participant of one of the groups, associates having a card of the health center as being assured of good health. In another moment, in this same group, Georgia includes a little different perspective:

Georgia: I'm saying that it doesn't work to be willing to be healthy, to look for treatment, to take care of yourself and not have support for it. And it can take a long time. I mean (...) sometimes you have something really simple you have, like a skin problem, right? It will get bigger, why? It takes forever to make an appointment for you. The...dermatologist, dentist, ophthalmologist, psychologist. Everything is so slow. Everything is so slow. Until things happen, it gets bigger, why? Because it takes forever. The case gets worse when the person can not afford treatment. I mean, you need the appointment and depending on the need... it takes longer. Myself with the dermatologist....

Soraia: The field of ophthalmology, dentistry, dermatology... it is so difficult.

Here, the access to the care is discussed under another perspective. The participants agreed that the search for health cannot be unilateral, depending on them alone, but it also depends on a process between the user and the health professional and also on the concrete access to the health professional.

We built the second theme "You think I took the medication the doctor prescribed?" taking moments in which the issues of non adherence to the treatment or to the follow-up were described as self care and not as patients' negligence.

Vivi: I dont buy it, I dont buy it!!!! [she says angrily] I go to another doctor [referring to medicines prescribed without good investigation].

Silei: They look at you, you tell them what you have and they prescribe it [the medicine] to you. I know already what I will get. Voltarem!!! [medicine for inflammation]. This Voltarem took over my life. And I say "this is not possible!" I go there to the Health Center...

Lucélia: Do you think that I took the medication the doctor prescribed? In the Health Center? It is closed, put aside in my house. I mean, I will not take this medicine for which she didn't make the prescription properly, didn't do an examination, nothing. How can I take this medicine? I can not take it. And I will not.

Worried with what they experienced as an insufficient medical listening and with what they consider to be a bad performed exam, which according to them, lead to a poor prescription, the participants reported they found not following the professional guidance, a viable solution to protect themselves. Considering that the participants do not share the same meanings regarding what a good prescription is or a good consultation, this conversation allowed us to learn several meanings from those who, according to a very diffused conception, are ignorant and/or resistant, do not exercise the self-care for not following the “medical orientation”. In another perspective, these participants talk about a great concern with their health and for this very reason, they cannot adhere to a treatment or take a medication prescribed by a professional who did not hear them the way they believed necessary for a correct comprehension of their complaints.

Thinking of the non-adherence as a form of a person taking care of herself, allowed us to recognize an user compromised with his(er) own health; it also implies rethinking important differences in the relationship professional/user in a context in which these people face delicate situations of unbalance in their health, situations that require a mutual understanding of what is important and necessary in the health care.

The third and last theme of the second axis “what we understand by health and what the doctor understands by it” is related to the disagreement between the ‘feeling sick’ and ‘being considered sick’ and vice-versa, that oftentimes occurs between the patient and health professional. The two examples bellow might illustrate this idea:

Márcia: Like one day, right? The girl had a fever for two days. I took her to the doctor. The doctor looked at us and said: “Your daughter has nothing”. “One more day and it will cease”. Well, the fever didn’t cease. Next day I took her there again. Then, a stupid lady told me that - she is not even a doctor – she told me: “Mother, but you brought her yesterday, you are bringing her again? You have to bring her in three days time.” Then I told her: “But there are many mothers that in three days lose their kids”. Then she told me: “If you sit here outside, you will see that each person has a story to tell you”. With the doctor it is the same bullshit.... (...)

Cira: Every time you take them there, those things happen. Everything is so negative that it seems the medicine will not even have an effect anymore.

Second example:

Nice: Another aspect of health is what we understand by health and what the doctor understands by it. So, this is something like, which I learnt, because I have a lot of experience, because sometime, for the doctor you are considered with some disease, right? Like in my case, I have hypertension. So, it is considered a disease, right? But sometimes we can, even have the disease but, when it is well controlled, we feel healthy, right? We know it. So, I think there is this other side of the question. Because we carry this heavy side of the disease: “No.. I... Well, I’m ill, I have this, I have that”,

right? But this is the doctor's point of view, because many times, when well controlled, you feel healthy.

In the first example, Mácia reports a situation in which she believed her daughter was sick and felt disoriented and neglected by the health professionals who assisted her. In the second example, Nice reports a reverse situation in which, she was feeling healthy but was considered a sick person with limitations in the medical point of view. In both situations, what was considered health problems that deserve attention depended on the places occupied in these relations. For the users, feeling sick or healthy is a matter related to their daily lives, whose meanings are produced according to their references, frequently different from those experienced by the health professionals. For the latest, the understanding of what is a health problem and how to treat is produced in a discursive context usually very diverse from the community. Such disagreements sustain relations of distrust/disbelief of the users regarding the professionals, the treatment and to the health system itself, and vice-versa. In a vertical health care system, not negotiable differences in the understanding produce, brings as a consequence, critiques and dissatisfactions from both parts, reducing the possibilities of producing shared practices in the health care.

Final Considerations

The group conversations favored the understanding that these participants demand a specific type of health care, depending on the moment of life they are. When talking from the perspective of a healthy person, the health promotion was privileged; however, when talking about some disease or fragility, the access to the services and professional interventions to provide recovery was the required instrument. The proximity and talks with these participants generated the reflection about multiple meanings produced about such themes and terms regarding health in the daily life. In the talks based on the need of specialized care, besides the importance of the access issue (consultation, medication, exam), what seem to be essential for the group participants, in our understanding, was the difficulty in accessing these kind of care.

The focus of this analysis was the repertory used in the construction of these meanings regarding health/illness in the discourse presented in the group and the participants' unfolding talks. We may say that the new discourses about expanded and integral health are present in the group talks; however, in the way the participants described their daily lives in these conversations, other meanings regarding the health/illness process, very divergent from the ones we produce in the contact with the current proposals in health, were constructed. Thus, we seek to give visibility, in these conversations to the several uses of these discourses in the talks. Initially, the development of each theme was based on the perspective of the more current discourses in health, disseminated in the scientific, academic and governmental areas, and were

directed to the self care, integrality, quality of life and citizenship issues. The talk also unfolded by the recurrence of other discourses available, such as the medicalized health.

Therefore, we understand the two axes of the analysis in this study refer to the health integrality issue, while the first one is focused on the perspective of integrality of the human being and the second one, on the integrality of the access to the health system. According to Mattos (2001), the integrality, in the context of SUS has unfolded in a diversity of meanings. Among those possible – related the organization of the services, the therapeutic practices or the work orientation – integrality always demands an attitude of refusal regarding the reductionism, to the subject object, always searching for a possibility of dialogue.

We sought, with the proposed analysis, to give visibility to how the users participants, in their histories narrated in the group, also refer to the discourse of integrality in the health care. They talked about the health/illness process approaching it in its multiple aspects, treating the diverse levels of care as fundamental and legitimate.

Conceiving, according to the social constructionism theory (Spink, 1999; Gergen, 1985, 1997; Shotter, 1993), that the meaning making process about the world, things and people is supported on the different social practices in which people participate, we believe that the conversations in the group are strongly based on the concrete relationships of these people with the local practices in health, which they have experienced as users of the health services. As social practices situated in an ampler health system, these conversations, despite protocols and official discourses, are not produced in a assistance model totally diverse of the history that constructed them. Thus, we understand the group participants talked from the perspective of users of a health service living with a discourse tuned with the integrality of health but at the same time with a medical discourse of it.

By the proximity with these people in the groups, the dialogues and interlocutions that unfolded, we may question that the changes in the health care model, including actions as the ones privileged by the PSF, involves the challenge of inclusion of the users who also live with the more traditional practices and discourses. The incorporation of the talk in the health professional/user's relationship has been a strategy emphasized and largely disseminated to transform the health assistance model (Andrade & Vaistman, 2002; Vasconcelos, 1999; Anderson, 1996).

However, the interaction processes between professional/users, in the health context, have been frequently regulated by conceptions consolidated in the tradition of a professional who holds the knowledge and relates with an alienated user aiming to educate him(er) for a better health behavior. This relationship stiffed by the hierarchies does not seem to contribute with the transformation of the health system. It is not about denying the differences and specificities of the knowledge held by the team. It is about considering the user as one who also holds a specific knowledge, from which the action in health gain meaning for them.

The present study intended to stimulate the reflection about aspects considered essential to the emergency of new possibilities of interaction in the construction of health practices. Through the analysis was possible to visualize the polysemy of discourses many times considered universal about health care. Denaturalized them, while unique, and give visibility to how it always is refereed in local contexts, producing in each situation and in each meeting, news meanings, invite us to see the conversational processes as social practices that help to (re) produce a shared model in the health care.

Conceiving the health/illness process as situated and contextualized, moreover, generating a network of relationships in which needs are constructed by means of a dynamic and dialogical process between those involved, also invite us to the construction of a practice more sensitive to the interactions, to the listening and to the permanent negotiation between health team-community.

In this way, a closer proximity between the social actors is valued, favoring opening spaces for conversations and consensus, in which the dialogue is the master tool of the relationship, allowing the construction of new meanings in the specificity of local assistance.

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Translated by Arlete Soares Belluzzo

Translated from *Interface*[on line]. Sept./Dec. 2005, vol. 9, nº. 18, pp.507-519. ISSN 1414-3283.