FAMILY HEALTH STRATEGY PROFESSIONALS AND USERS' PERCEPTION ON HEALTH PROMOTION GROUPS[1]

Lucia Helena de Souza Alves[2], *Astrid Eggert Boehs*[3], *Ivonete Teresinha Schülter Buss Heidemann*[4]

[1] Paper taken from the thesis – Health promotion group in the Family Health Strategy (FHS), presented to the Graduate Nursing Program (PEN) at *Universidade Federal de Santa Catarina* (UFSC), 2010.

[2] M.Sc. in Nursing. Faculty, Undergraduate Nursing Program at *Centro Universitário para o Desenvolvimento do Alto Vale do Itajaí*. Nurse, Family Health Strategy, Municipal Health Secretary of Navegantes. Santa Catarina, Brazil. E-mail: luh_11@hotmail.com

[3] Ph.D. in Nursing. Associate Professor, Nursing Department and PEN/UFSC. Santa Catarina, Brazil. E-mail: astridboehs@hotmail.com

[4] Ph.D. in Nursing. Adjunct Professor, Nursing Department and PEN/UFSC. Santa Catarina, Brazil. E-mail: ivonete@nfr.ufsc.br

ABSTRACT: In this participative and qualitative research, the aim was to get to know how Family Health Strategy users and professionals perceive health groups developed in a city in Southern Brazil. For collecting the data, Freire's itinerary was used in six culture circles with professionals/users of two teams. Twenty-four themes were investigated and unveiled in two major themes, which were analyzed based on the Ottawa Charter. The study results showed that health promotion actions developed in these groups are strongly connected to the reorientation of the health services and the development of personal skills. The leisure actions developed have shown some cross-sector relations and social participation. The method used in this research permitted approximations between professionals/users, as well as dialogue about the situations and themes brought up. It was concluded that health promotion actions need to be expanded in these groups and that the culture circle Paulo Freire proposed is a possible tool for the construction of participatory and emancipatory health practices.

DESCRIPTORS: Health promotion. Health education. Family health. Nursing.

A PERCEPÇÃO DOS PROFISSIONAIS E USUÁRIOS DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA SOBRE OS GRUPOS DE PROMOÇÃO DA SAÚDE

RESUMO: Pesquisa qualitativa participativa, que objetivou conhecer a percepção dos usuários e profissionais da Estratégia Saúde da Família sobre grupos de saúde desenvolvidos num município do Sul do Brasil. Utilizou-se o itinerário freireano em seis círculos de cultura com usuários/profissionais de duas equipes, sendo investigados 24 temas e desvelados em duas temáticas significativas, analisados à luz da Carta de Ottawa. Os resultados indicaram que as ações de promoção da saúde realizadas nestes grupos estão fortemente alinhadas com a reorientação dos serviços de saúde e o desenvolvimento de habilidades pessoais. As ações de lazer efetuadas mostram indícios de intersetorialidade e participação social. A metodologia utilizada possibilitou aproximações entre profissionais/usuários, e diálogo em torno das situações e temáticas levantadas. Conclui-se que as ações de promoção necessitam ser ampliadas nestes grupos e que o círculo de cultura proposto por Paulo Freire é uma ferramenta possível à construção de práticas de saúde mais participativas e emancipatórias.

DESCRITORES: Promoção da saúde. Educação em saúde. Saúde da família. Enfermagem.

LA PERCEPCIÓN DE LOS PROFESIONALES Y USUARIOS DE LA ESTRATEGIA DE SALUD DE LA FAMÍLIA SOBRE LOS GRUPOS DE PROMOCIÓN DE LA SALUD

RESUMEN: Esta es una investigación cualitativa participativa que tuvo como objetivo saber la opinión de los usuarios y del equipo de la estrategia salud de la familia acerca de los grupos de salud desarrollados en una ciudad en el sur de Brasil. Para la recolección de los datos se utilizó el Itinerario Freireano en seis círculos de cultura con usuarios/profesionales de dos equipos, se investigaron 24 temas y se priorizaron en dos temas significativos con sus análisis basados en la Carta de Ottawa. Los resultados mostraron que las acciones de promoción de salud realizadas en estos grupos están fuertemente dirigidas a la "reorientación de los servicios de salud" y el "desarrollo de habilidades personales". Las acciones libres desarrolladas muestran aspectos de intersectorialidad y participación social. La metodología utilizada posibilitó aproximaciones entre profesionales y usuarios, y también el diálogo en torno a situaciones y temáticas detectadas. Se concluye que las acciones de promoción de la salud todavía necesitan ser ampliadas en estos grupos y que los círculos de cultura propuestos por Paulo Freire son una posible herramienta para la construcción de prácticas de salud participativa y de emancipación.

DESCRIPTORES: Promoción a la salud. Educación en salud. Salud de la familia. Enfermería.

INTRODUÇÃO

As from the Ottawa Charter in 1986, health promotion has been defined as the process of enabling people to improve their quality of life and health, including further participation in the control of this processs.[1] The main strategies are the "implementation of healthy policies; the creation of environments that are favorable to health; reorientation of health services, reinforcement of community action; and the development of personal skills".[2:353]

In Brazil and several Latin American countries, where socioeconomic inequalities still prevail, health promotion still plays a small role in countries' social and economic development.[3] Many proposals have been created in the health area to develop promotion actions though, mainly aiming for the reorganization of healthcare and the Unified Health System (SUS).

Health promotion actions in the Family Health Strategy (FHS), through health education, represent a "route to integrate care, a space for reflection-action, based on technical-scientific and cultural, popular knowledge, which enhances democratic practice, capable of provoking individual, family and community changes and contributing to social transformation".[4:340] The Health Education concept is anchored in the "Health Promotion concept, which considers processes that comprise the entire population's participation in the context of their daily life, and not only people at risk of illness".[4:339] Group education activities are encouraged in the FHS, as it is believed that they enhance participation, guaranteeing the possibility for individuals and communities to decide on their own destinies and enabling them to improve their living condition.[5] Studies show, however, the population's resistance even when groups are offered in the FHS. One study[6] refers that, among interviewed FHS users, only 14.4% participated in some extra-consultation activity. As for the interviewees' relatives, 7.6% participated in some activity, the most reminded of which was the hypertension league. In one study[7], the authors appoint the following causes of resistance: the tension level these people live with; tension resulting from an extremely precarious social reality. In addition, there is the fact that health professionals, supplied with health knowledge that is recognized as the only legitimate source, can be considered in a position of superiority towards "those people who have neither education nor knowledge".[7:587] Another issue is that the groups organized around chronic patients, like hypertensive and diabetic individuals, are common at primary healthcare units (UBSs), and that lectures followed by questions are still frequent.[8]

Within the reality in Southern Brazil, where FHS teams in many cities already practice health education groups on a regular base, the following question emerges: how do professionals and users perceive these groups?

The aim of this study was to get to know FHS team professionals and users' perception about the groups developed at two FHS units in a city in Southern Brazil.

METHOD

This participative and qualitative research was articulated with the phases of Paulo Freire's methodological framework, known as Freire's itinerary. These three phases are closely related: thematic investigation, aimed at identifying generating themes taken from the participants' reality; coding and decoding, in which the generating themes are contextualized and problematized; and critical unveiling, including awareness about reality.[9-10]

Data were collected through cultural circles, which are spaces of learning and knowledge, with dialogue as a fundamental element, arousing the subjects' action and reflection about existential situations, addressing important themes in their daily reality.[11] This gives rise to the researcher's participatory nature as an animator of the cultural circle, in which all members play an active role.

The cultural circles were developed at two health units located in two neighborhood in a city in Southern Brazil, with mutually distinct socioeconomic and cultural characteristics, which were called Unit A and Unit B. In total, 31 people participated in the circles, including 16 professionals with a mean age between 20 and 50 years, and 15 users between 50 and 75 years old. The female gender was predominant at both units.

At Unit A, in total, 11 people participated in the cultural circles (one nurse, one nursing technician, one dental hygiene technician, one administrative aid and seven Community Health Agents (CHAs), which were held on the occasion of monthly team meetings at the unit's meeting

room. At this unit, no users participated as, due to frequent team member changes, the health groups had been temporarily deactivated.

At Unit B, twenty people participated (15 users, two nurses, one physician and two CHAs), predominantly users. The circles took places during the health group meetings at the Neighborhood Association.

Applying Freire's itinerary, three circles were held in each neighborhood, totaling six, during the second semester of 2009. The approximate duration of each circle, involving the team at Unit A as well as users at Unit B, was approximately one hour. The culture circle at Unit B happened differently from Unit A as, due to the fact that users and professionals were present in the same space, initially, users felt somewhat intimidated. As a result of the chairs' arrangement in circles and the horizontal dialogue among participants, however, the circles represented an important space to overcome weaknesses, arousing reflection and analysis of group activities.

To start the meeting, the cultural circle activity was accomplished, followed by programmed activities. All participants, including the researcher, sat in a circle to facilitate and stimulate horizontal dialogue.

To register the data, an audio recorder was used, with the participants' previous authorization, and a field diary. Two undergraduate Nursing students participated, who helped with the recordings and field records. To facilitate the organization of the collected data, they were later transcribed and filed in separate folders, according to the group in which the cultural circle took place.

To start the cultural circle activities, the following guiding question was used: Wht is the importance of the group activity to you? Starting from this question, the research themes, coded and decoded, were discussed during the circle meetings and then unveiled. Based on the research, the participants selected three themes: difficulty to accomplish dialogue among professionals and with users; development of disease-focused activities, no clarity about what a group is; and the method used does not respond to the group's expectations, which were coded and decoded. The critical unveiling occurred at the same time as new themes were identified, which emerged from each cultural circle. The meaning the participants expressed about the health promotion/education groups was the key focus of reflection and action during the meetings. The theoretical framework of Health Promotion, in the light of the Ottawa Charter, supported the assessment of whether health and education actions were taking place in the FHS.

Approval for the project was obtained from the Research Ethics Committee at *Universidade Federal de Santa Catarina*, under Opinion No. 045/09. To comply with ethical principles and in the attempt to preserve anonymity, participants were identified through the following letters: "U" (Users) and "P" (Professionals). All participants signed the Informed Consent Term at the start of the first cultural circle.

RESULTS

Thematic investigation

The first phase, called thematic investigation, was aimed at surveying the generating themes. To facilitate dialogue, the circle animator stimulated debate through some inquiries about the aims, difficulties and methods addressed in the groups. These discussions were held at Unit A as well as Unit B.

At Unit A, 16 generating themes were investigated during the cultural circles, associated with the group's activities. Among these themes, three were highlighted as the most relevant. The first was related to the frequent nursing professional turnover, disclosing conflicting situations, which made the other professionals feel anguished and appeared as a moment of relief for the participants, as clarified in the following statements: [...] *the nurse went there and talked about food, about care with salt, about drinking fluid, all of that basic care and orientations* [...] *then another nurse* [...] *did the same thing...then nursing changed again, the head* [...] *and the same thing* [...] (P1 A).

The second theme mentioned referred to the method and language the higher-education professionals used to conduct activities, as observed in the following statement: [...] *it's like, our people there, they're mostly elderly, they don't have much education, they experience a lot of difficulty to understand what the professionals says, the language*[...] (P3 A).

The third theme emphasizes disease-focused group activities that happened repeatedly, which was not very attractive for users' participation,

who preferred diversified and recreational issues, as follows: [...] *then they found it very interesting, because it was something… they did not imagine, because they thought it would be discussing about salt again* [...] *and in the end the theme was different, and then they were very participative… but it should be less repetitive* [...] (P1 A).

In the cultural circle at Unit B, eight significant themes emerged from group activities, three of which were appointed as the most relevant. The first, called "many activities for the elderly to participate in", is related to the participants' age. It is important to highlight that most participants were elderly and experienced transportation difficulties to take part in group activities. Today, the city has organized a range of leisure activities, increasingly attempting to include this population in society. These are not developed in partnership with the health units though. Thus, when the groups the health units promote take place on the same dates as the other activities, they choose recreation, which the professionals criticize, as follows: [...] *people should respect, take advantage and come here, right. Leave aside the party, the bingo and come* [...] (U1 B).

Another relevant theme that significantly influenced group participation was the time when meetings were held, in the afternoon, and the compulsory participation in meetings, as medication was supplied, according to the following statement: [...] *I think it's an obligation we have, today we are well attended, get the medicines, that's an obligation. I think it would be an obligation for us, we're already retired, it's not difficult, I think* [...] (U1 B).

Another theme discussed in the cultural circle was that many people invent apologies for not participating in the meetings. It is believed that this is due to their lack of knowledge about the actual objectives of a group and, often, because the methods developed are hardly dynamic and users prefer more participative and recreational methods.

Another theme addressed was that many people think that the group is only for the elderly, diabetic and/or hypertensive patients. This view may be linked with the health model the city adopts, which used to focus on educational issues related to chronic illnesses, and that there is a dissemination problem, because it is not clear, as follows: [...] *it's something else, it's like, oh, they get kind of lost, oh… that it's not just for elderly people. The gymnastics, the group, it's for everyone who wants to take part* [...] *further dissemination is needed* [...] (U4 B).

In the second phase of the research itinerary, the intent was to discuss the themes investigated during the first phase, as described next.

Coding and decoding of themes

In this phase, the themes were contextualized through coding and decoding, involving dialogue, and problematized according to the themes raised in the research. A more profound reflection on the themes identified was debated on during a cultural circle with the advisers, who contributed to discuss and direct the groups' most relevant problems at Units A and B.

In the cultural circle at Unit A, on that day, only eight professionals were present. A short retrospective of the previous circle was presented and, then, labels with the generating themes surveyed during the first circle were exposed on the magnet board for the sake of validation. This served to give everyone a better sight of the themes and proceed with their analysis. In this universe of 16 generating themes, it was investigated that many of them were interconnected through coding and decoding.

Then, reflection happened, coding and decoding the three themes selected in the research phase. In the statements, during the circles, themes were registered related to difficulties to dialogue: [...] *we never have space* [...] (P6 A). These data mainly expressed staff turnover at the unit, coded as the lack of bonding and disrespect among professionals with a lower education level. Similarly, it was perceived that group activities were focused on disease. The focus reproduced the hegemonic medical model, with a banking work method. It was identified that the professionals, especially the nurse, passed through the unit without considering previous experiences, misinterpreting the focus the city attributed to the groups.

At Unit B, the coding and decoding phase took place during the second cultural circle, when the themes were again presented for the sake of validation and discussion.

In this case as well, three themes were coded and decoded as the most significant: 1. The group dynamics does not stimulate users' participation; 2. The group permits experience exchange; and 3. Lack of dissemination.

The participants evidenced that the dynamics used in group activities did not stimulate users' participation, as witnessed in the following statements: [...] *We've already talked about diabetes and hypertension the whole time, the whole time* (U2 B).

At the end of last year, there were much more people than today, because there was the scavenger hunt (U4 B).

In this phase of the itinerary, the participants also discussed positive considerations regarding their participation in the group. It was discussed that this moment enhances knowledge gains through experience exchange, establishment of friendships, stimulates reflection and awareness about the reality experiences, besides a broader social circle, leading to a better quality of life.

One theme discussed in the circle referred to the lack of dissemination about issues related to the group objectives, target public, as well as place, time, hours and approaches, so as to improve quality and participation in the meetings. *You have to say more that everyone can go to the group* [...] *you have to disseminate it more in the community, in the elderly group too* (U4 B).

On the other hand, the cultural circle took place calmly. Participants showed to be very receptive and seemed to be more at ease with the professionals' presence during this moment of dialogue than in the previous circle.

Critical unveiling

The critical unveiling phase is the third moment in Paulo Freire's research itinerary. The themes that had been coded and decoded returned to the debate during the last cultural circle for reflection and awareness-raising on the participants' reality in the groups at Units A and B. At this moment, the unveiled themes showed to be similar at both units and were debated on among the circle participants, aiming for problematization and reflection, so as to discover the limits and possibilities of thematic investigation. Also, reflection took place together with the research advisors.

To proceed with the unveiling of themes, a group dynamics session was held at both units, when participants were divided in two small groups, each with the support of a monitor. To stimulate dialogue, participants debated on questions about health education actions in small groups and wrote down discussions on a sheet of paper, exhibited and discussed in the big group. Activities in the circles started with a synthesis of the thematic investigation and a presentation and repeated panel discussion of the coded and decoded themes.

Among the themes investigated, coded and decoded at units A and B, two relevant themes were prioritized in the critical unveiling phase: 1. There is no clarity, lack of knowledge about what a group is; 2. Method used in the group.

To proceed with the critical unveiling during the circle meetings, the following questions were debated on at the units: "What is the purpose of the groups in the FHS?" "What do we need for the groups to work?" Based on the dialogue produced in the circle, the participants unveiled that the group serves as a form of orientation to prevent diseases and improve their quality of life, as follows: *to advise the people and professionals who are participating, to have more information on the diseases and other topics* [...]. *To do prevention, stimulate people to take care of themselves, to avoid diseases, have a healthier, a better life* (P2 A).

It was discussed that, for the groups to work, better relations between professionals and users should be aimed for, as well as changes in the method used during group meetings, and more dialogic attitudes should be adopted among the participants: *the professionals should commit more, respect times, take responsibility* [...] *respect the participants, not change the group themes without warning, because that creates false expectations for them* [...] (P3 A).

They questioned that dissemination about the group and meeting aims is not happening correctly and needs to be enhanced. Partnerships should be established with other activities in the community to further participation. The method should be reconsidered, including recreational/ leisure activities, practice group sports, address other daily-life issues, like in the following opinions: *accomplish leisure activities, as these give more of an uplift, call more attention* [...]. *Group sports are another form of health promotion, interaction*[...] *singing groups help with health, as who sings gets rid of all problems, cool down your head* (U5 B).

On the other hand, they reflected positive attitudes towards the health groups, unveiling

that they serve orientation and disease prevention purposes and are a space for experience exchange/learning, for moments of coincidence and equality among participants. They also emphasized the need to broaden these themes with the team and the commitment all participants should assume towards themselves and the group; and that, together, they should plan/set goals to turn the groups into a pleasant space of health promotion.

It should be highlighted that, in the final assessment at Unit B, the professionals affirmed that they were surprised about the users' reflections and expectations in this group. They reflected on the change in health promotion practices and asked for the dialogues/inquiries to be exhibited to the entire FHS during weekly team meetings.

DISCUSSION

Returning to the action areas of the 1986 Ottawa Charter, the study results show that the health promotion actions the FHS teams under analysis perform are more strongly aligned with the reorientation of health services and the development of personal skills.

Thus, although the reorientation of health services is taking place through the existence of so-called Health Groups, the data also reveal that they partially exist out of compliance with the standards and routines the FHS dynamics impose in response to the aim of restructuring public health services in Brazil, with the development of health promotion actions as a basic premise.[12-13]

The activities developed in the Health Groups in this study also continue, despite the new name, according to users and professionals' perceptions, focused on disease and using traditional methods. Thus, education turns into a depository act, in which the educator (health professional) educates, chooses the program contents and is the subject of the process, while the students (users) are mere objects to be educated, denying dialogicity.[12] This method discourages users' participation, as they prefer to dialogue about diversified themes related to their daily life and dynamic activities.

The data also indicate, however, that health promotion actions in the city under analysis are going through reorientation, as the multiple leisure attractions are competing with the activities the health units perform. This reality shows a great possibility of intersectoral work for health professionals, broadening activities to include the other action spheres of the Ottawa Charter.

Despite advances in activities beyond individual care, according to this study, the strong influence of the individual, curative model on health services continues, which entails the strong alignment of users and professionals' perception with the action sphere in the development of personal skills. Breaking with this individual health model and practicing dialogue remains a great challenge, as observed in the data that revealed difficulties to understand the concept and disease prevention and health promotion practices, for professionals as well as users. According to the Brazilian Association of Graduate Programs in Collective Health (ABRASCO), this is in accordance with Brazilian authors' historical analysis, appointing difference conceptions about health promotion in society, which are not in line with the academic concept.[14]

In this sense, it is important to work with liberating education, Paulo Freire's methodological ideas, through the cultural circles, which enhance dialogue, permit participants' autonomy, mainly in education and health groups, characterized by the adoption of traditional and banking methods in actions involving users and health professionals.

Working with the stakeholders through a non-coercive method is a distinguished action that enhances the subjects' participation and empowerment. It is important to maintain the notion of bonding, reassessing the environments the groups are inserted in, mainly because group activities are directed at the risk factor prevention models and their practice is ignored. Advancing in the effectiveness of health promotion actions in the groups demands great efforts towards a better quality of life and the transformation of social conditions.

It should be highlighted that, within the health promotion spheres of the Ottawa Charter, health professionals and users should be subjects of the same process and seek individual and group strengthening.[15] Thus, the accomplishment of the cultural circles gave voice to the participants, for users as well as for professionals, and showed that they can participate more actively. It entailed approximation among professionals at Unit A and between professionals and users at Unit B, creating

conditions for dialogue about the aspects related to their life and health reality.

Health promotion is related with the groups quite significantly, through the empowerment category, which treats power relations in a horizontal way, permitting the development of competences and skills for life in society.[15] Empowerment "is expressed through the communities' technical and political power".[16:85] In this conception, group work becomes especially relevant.

In this respect, the cultural circles Freire proposes contribute to the group's empowerment and strengthening, mainly through the interactions established, bonds of trust and respect for particularities, constructed through their not only educative and preventive, but also transformative effect on the socially involved subjects.

FINAL CONSIDERATIONS

Returning to the aim of getting to know how users and FHS team professionals perceive the groups at a city in Southern Brazil, it should be highlighted that the method used permitted approximations among the professionals and between professionals and users, involving dialogue about the situations and themes raised. Based on the cultural circles, the reality the participants experienced started to be unveiled.

According to the professionals and users' perceptions, although the themes and methods in the groups remain more strongly aligned with two Health Promotion fields in the Ottawa Charter, they give clear signs of opening to the other fields, which can be further encouraged through the use of methods like Paulo Freire's proposal.

Based on these results, FHS teams should heed the concept of health promotion and the action strategies of the Ottawa Charter, valuing the sociocultural resources in their coverage area and doing intersectoral work. In addition, the group method lacks a review of how the teaching-learning process can be addressed in these spaces.

For the future, comprehensive evaluation research is recommended about the use of the group mode in the FHS and about the effectiveness of health promotion, mainly in relation to the action fields proposed in the Ottawa Charter. In these studies, it is important to investigate different professions' insertion in these groups, the professionals' education, methods use, difficulties faced, sustainability strategies, health promotion surveillance and its action practices and how intervention in these spaces can enhance equity in health.

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Correspondence to: Lucia Helena de Souza Alves
Rua José Gall, 1089, ap. 303
88307-100 – Dom Bosco, Itajaí, SC, Brasil
E-mail: luh_11@hotmail.com