

EDUCATIVE PRACTICE OF COMMUNITY HEALTH AGENTS ANALYZED THROUGH THE CATEGORY OF PRAXIS

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This study aimed to: analyze the conceptions of health education that guide educational practices of community health agents in the Family Health Program of the Butantã Health Coordination, São Paulo, Brazil, and analyze the character of these educational activities. Data were collected through focus groups and in-depth semi-structured interviews with 39 agents. The analysis procedures followed the recommendations of thematic content analysis, and praxis was the analytical category. Regarding theoretical activity as a component of praxis, we found that most health education conceptions were based on the transmission of normative information learned from health technicians. This theoretical activity ended up guiding a practical activity typical of repetitive praxis, in which the agents do not participate in the health work planning process and do not dominate the "ideal object", reproducing tasks planned by others.

DESCRIPTORS: health education; community health agent; Family Health Program

LA PRÁCTICA EDUCATIVA DE LOS AGENTES COMUNITARIOS DE SALUD A LA LUZ DE LA CATEGORIA PRAXIS

Este estudio tuvo como objetivos: analizar las concepciones de educación en salud que orientan las prácticas educativas de los agentes comunitarios de salud en el Programa de Salud de la Familia de la Coordinación de Salud de la Alcaldía menor de Butantã en la ciudad de São Paulo, Brasil; y analizar el carácter de esas actividades educativas. La colecta de datos ocurrió por medio de grupos focales y entrevistas individuales con 39 agentes. Los procedimientos de análisis siguieron las recomendaciones del análisis temático, teniendo la praxis como categoría de análisis. En relación a la actividad teórica, componente de la praxis, se constató que gran parte de las concepciones de educación en salud se basaba en la transmisión de informaciones normativas aprendidas con los técnicos de salud. Esa actividad teórica acabó por guiar una actividad práctica característica de la praxis reiterativa, en que los agentes no participan del planeamiento del proceso de trabajo en salud y no dominan el "objeto ideal", reproduciendo tareas planeadas por otros.

DESCRIPTORES: educación en salud; agente comunitario de salud; programa salud de la familia

A PRÁTICA EDUCATIVA DOS AGENTES COMUNITÁRIOS DE SAÚDE À LUZ DA CATEGORIA PRÁXIS

Este estudo teve como objetivos: analisar as concepções de educação em saúde que norteiam as práticas educativas dos agentes comunitários de saúde do Programa de Saúde da Família da Coordenadoria de Saúde da Subprefeitura do Butantã da cidade de São Paulo, e analisar o caráter dessas atividades educativas. A coleta de dados ocorreu por meio de grupos focais e entrevistas individuais com 39 agentes. Os procedimentos de análise seguiram as recomendações da análise temática, tendo a práxis como categoria de análise. Em relação à atividade teórica, componente da práxis, constatou-se que grande parte das concepções de educação em saúde se pautava na transmissão de informações normativas aprendidas com os técnicos de saúde. Essa atividade teórica acabou por guiar uma atividade prática característica da práxis reiterativa em que os agentes não participam do planejamento do processo de trabalho em saúde e não dominam o "objeto ideal", reproduzindo tarefas planeadas por outros.

DESCRIPTORES: educação em saúde; agente comunitário de saúde; programa saúde da família

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INTRODUCTION

This study looks at health education as a social practice carried out by Community Health Agents (CHA), who are perceived as agents of change in view of the implantation of the Family Health Program (FHP). Health education is one intervention instrument, recommended and acknowledged by the Brazilian Health Ministry through Law 10.507, which creates the profession of CHA. Community Health Agents' activities are characterized by disease prevention and health promotion, developed according to the guidelines of the Single Health System (SUS) and under a local manager's supervision⁽¹⁾.

This study starts from documentation about CHA in the State of São Paulo, joined from 1981 onwards through the DEVALE Project (Project for the Expansion of Basic Health and Sanitation Services in Rural Areas), which was part of the PIASS Program (Program for the Interiorization of Health and Sanitation Actions)⁽²⁾.

PIASS, developed in the mid-1970's, was one of the most expressive Health Coverage Extension Program (PEC). Guided by North American Community Medicine conceptions, the program aimed to mitigate, through focal actions, conflicts deriving from social inequalities⁽³⁾.

Community action attempted to act on already installed health problems, restricting actions to the consumption sphere, without interventions that would reach the labor world. It was based on community participation, with the clear intent to provide orientations recommended by health staff, leaving the final say up to the technician. Moreover, the population's participation was requested to solve problems based on limited local resources, to the detriment of structural transformations that would adequately attend to the health needs of the social groups that comprised a given community⁽³⁾.

At the end of the 1960's, community action programs and the Community Medicine movement were brought to Latin America and to Brazil, mainly through the Pan American Health Organization (PAHO) and North American private foundations⁽³⁾.

The creation of this kind of projects was associated with the UN (United Nations) resolution that called upon rich countries to promote help to poor countries after World War II, as a strategy to remove the danger of Eastern European communist ideologies' expansion. Thus, the US promoted technical

assistance projects for countries at the periphery of capitalism, mainly from Latin America, including Brazil, developing countless experiences. In principle, these were focused on rural and small sites and were addressed in different studies⁽⁴⁾.

This principle was strengthened from the 1970's onwards by means of the capitalist crisis, whose answer was the economic, political and ideological project of neoliberalism. Through the fight against the State of Social Well-Being, global capital gained the adherence of a State that established official rationalized public health care models at a minimal cost, allowing the private sector to explore health as a commercial good⁽⁵⁾.

"In view of this picture, it is important to consider the meanings increasingly attributed to the right to health, in a scenario in which the arrangement between the public and private sector are not always guided by an inclusive ethical rationality, where miserability and so-called social vulnerability situations define the privileged project of social policies (...). [and where] the way sanitation policies are funded and operationalized appoints the public-private articulation, exempting the State from its role as a guarantor of rights"⁽⁶⁾.

Hence, the FHP ended up being a compensatory program, in a context where public services were transformed into Social Organizations⁽⁷⁾. It is not "difficult to associate this care model with the family/community medicine model. It is obvious that, in order to offer the essential minimum package, specialists are not necessary, not even in basic specialties, nor investments in the qualification and modernization of the service network (...)"⁽⁸⁾.

Based on the premise that CHA institutionally participate in the concretization of this project and can therefore develop educative actions to make individuals and families accountable for the solution of their health problems, this study aimed to: analyze the education, health and health education concepts that guide CHA's educative practices; analyze the character of educative activities carried out by CHA from the Health Coordination Office of the Butantã Municipal Government.

THEORETICAL CONSIDERATIONS

Praxis appears as a potent analytic category to explain the connection/discussion between

accumulated knowledge (experience/training for work/intentionality of community health agents as agents in the health work process) and the concretization of this project.

Praxis refers to the human action that transforms nature, based on the theory that exists to guide the action, that is, "praxis presents itself as a material and transforming activity that is adjusted to objectives. Outside praxis, there is theoretical activity, which is not materialized, to the extent that it is purely spiritual. But, on the other hand, praxis does not exist as a purely material activity, that is, without the production of goals and knowledge that characterize theoretical activity"⁽⁹⁾.

What characterizes actual human activity is the awareness of actions, which are directed towards an object in order to transform it and whose final result tries to get near the ideal result. Thus, **praxis**, as a material practical activity guided by conscience (theory) in order to transform nature on the basis of an intentional project, is differentiated from general activity⁽⁹⁾.

Theory can present itself as theoretical activity to the extent that it transforms perceptions, conceptions or concepts, that is, when both objectives and knowledge are produced. However, theoretical activity alone does not transform reality, as "its activity is not objectified or materialized"⁽⁹⁾. This is an imperative characteristic of praxis and, therefore, we cannot talk about theoretical praxis.

Theoretical activity is distinguished from practice in terms of object, goals, means and instruments. If the *object of practical activity* is *nature, society or men*, its *goal* is the *transformation* of the natural or social *world*, and the *result* is a *new material reality*; in *theoretical activity*, the *object* includes *perceptions*, concepts, theories and representations, and the *goal* is to *produce theories that explain current reality* or *outline goals* that ideally anticipate the transformation of reality, without its actual occurrence⁽⁹⁾.

On the other hand, the way conscience is present in the subject's practical activity configures different praxis levels. Thus, a distinction can be made between creative and imitative praxis. "Praxis appears either as imitative praxis, that is, in conformity with a previously established law, and whose execution is reproduced in multiple products that show analogue characteristics, or as innovative, creative praxis, whose

creation does not fully adapt to a previously established law and culminates in a new and unique product"⁽⁹⁾.

Imitative praxis favors the quantitative multiplication of a qualitative change provoked by creative praxis. As man does not live in an eternal creative state, since he only finds himself obliged to create when confronted with some need, he repeats while he does not create. However, this repetition needs to be transitory, as it is by creating that man transforms the world and transforms himself⁽⁹⁾.

Due to the unity between the conscience that projects and the hand that carries out the project, in a way, creative praxis erases the difference between manual and intellectual work⁽⁹⁾.

However, historically, this creative character of work, represented by handwork, was gradually replaced by mechanized work, due to capitalist society's requirements to increase production. Technical development itself gave rise to the growing division and specialization of work. "[Hence], the characteristic traits of creative praxis disappear from [man's] work (...). Workers' divided, unilateral and monotonous activity was previously determined, without their participation. That is, not only the goal of his activity, the ideal object he has to produce is fixed in an anticipated and complete way, but also any and all steps he will perform, without the possibility of deviations"⁽⁹⁾.

METHODOLOGICAL PROCEDURES

We carried out a qualitative and exploratory research. The study was carried out at regional Basic Health Units (BHU) under the responsibility of the Butantã Municipal Government's Health Coordination Office*, which covers the extreme West of São Paulo City, joining a population of 359,656 inhabitants on a geographical area of 56.1 km², divided in five Administrative Districts.

This research focused on the following units - BHU Jardim Boa Vista with 36 CHA, BHU Vila Dalva with 30 ACS, BHU Jd. São Jorge with 36 CHA and Butantã School Health Center (BSHC) with 12 CHA - the only units that could have CHU at the time of study.

The study population included all 114 CHU under the responsibility of the Coordination Office,

* Name used until the start of 2005, when the government changed and, consequently, the number of health coordination units was restructured from 31 to 5. The Health Coordination Unit of the Butantã Municipal Government was attached to the Health Coordination Office from the Central-West Region.

39 of whom volunteered to participate. Data were collected in June, July and August 2004, through individual interviews with two agents from each service and through group interviews - one group with five CHA from BHU Boa Vista, one group of six from the BSHC, one group of ten from BHU São Jorge and another group of ten CHA from BHU Vila Dalva.

In compliance with the ethical determinations of Law 196/96, the project was approved by the São Paulo Municipal Government Ethics Committee. All interviewees signed a Free and Informed Consent Term, authorizing the research and data dissemination.

Group interviews were selected on the basis of considerations by focus group specialists who adopt an emancipatory approach⁽¹⁰⁾. In this sense, we sensitized the CHA, asking them to reflect on situations they experienced in school that had some meaning in their lives. The addressed themes included in this article were: CHA's concept of education, health and health education, how health education is done in practice.

Individual interviews were held with agents who had not participated in the group discussion, using a semistructured script with the following themes: health education concept, description of educative activities, description of team supervision.

Individual interviews and group discussions were recorded with the participants' consent and transcribed, after which they were analyzed. Thematic data analysis was applied according to the following steps⁽¹¹⁻¹²⁾: recording of individual and group interviews; transcription of the full interviews by the researcher or with the help of another person; several readings of each individual or group interview, with a view to apprehending and interpreting them as closely as possible to the original discourse; elaboration of interview cards, writing down in the margin of the text themes and sub-themes according to previously formulated questions and problems, as well as new themes and sub-themes that emerged during successive readings; fragmentation of statements to construct units of meaning or themes, attempting to perceive other empirical and analytic categories based on the reports, with a view to organizing and interpreting their contents; content analysis, based on the theoretical premises and analytic categories that had been previously established or emerged from the empirical material.

The health services are identified as UBS I, UBS II, UBS III and UBS IV, respecting the order in which the groups were held. The texts of the individual

interviews are identified by the letter I and a number that also refers to the order in which the interviews were held, considering the set of units.

RESULTS AND DISCUSSION

Theoretical activity: how community health agents conceive health education

The largest part of the agents' discourse, obtained through the focus groups as well as individual interviews, reveals that the health education that permeates their work is guided by the transmission of information and recipes to achieve health, characterizing a **prescriptive** and **normative** activity. Consequently, less statements explained the health education concept as the result of a construction guided by respect for users' knowledge and experiences, considering their knowledge and perceptions about their health.

Prescriptive health education is configured as a transmission process of prescriptions to preserve or acquire health. The subjects of the education process are considered as a passive "target public", an object that is supposed to accept the technicians' guidelines, who possess scientific knowledge. CHA appear as pseudo-technicians, because they end up reproducing these guidelines without actually mastering the knowledge that engenders them.

The most frequent prescriptive health education statements fit into the theme "educating means providing focal information about health care".

[Health education means] Talking about a disease, talking about how to treat a disease, being capable of saying how the person should proceed, you know? The sick person, whatever, somebody with a heart problem, you'll say how this person should proceed, advise about certain diseases, you know... (UBS I).

Other themes like "educating means frightening users for them to prevent the disease" were also represented.,

That person did not take medication for pressure, for hypertension, she didn't do anything, she didn't measure her blood pressure, she didn't care so then I had to scare her, I had to use threats but I managed... (laughs). (UBS III)

The same prescriptive character was reproduced in the themes: "educating means promoting changes in habits", "health education means repeating the information several times", "health education means convincing".

This shows that health education conceptions are related to the goal of changing behaviors, whether by using convincing devices, which demands repeated information transmission, or by adopting frightening strategies.

This understanding of educative work is rather similar to Local Health System (SILOS) (SILOS)⁽¹³⁾ education, which is characterized by blaming the person for getting ill, making them responsible for controlling the disease. This is aimed at improving people's life situation based on individual resources, without contesting the structure and dynamics of the production mode, which engender the roots of health problems.

Thus, the goals of health education would be to: a) purge, extract beliefs and ideas that are unfavorable to the behavior expected by hegemonic academic knowledge; b) standardize, order individuals' life according to previously established standards, without considering subjects' previous knowledge and experiences or differences in social insertion; c) legitimize institutional practices and contents, whose knowledge is considered valid⁽¹⁴⁾.

In this perspective, education is practiced as the delegation of responsibilities to the individual and as an action that complements medical action, with a view to lowering the costs of social policies. The way health education is conducted ends up attributing the cause of health actions' failure to individuals' "ignorance" and "lack of awareness"⁽¹⁴⁾.

Thus, to overcome this "lack of awareness", very often, strategies are used to reinforce orientations and control on individuals' bodies⁽¹⁵⁾, in line with campaignist public health⁽¹⁶⁾. Popular knowledge is often denied and scientific knowledge is imposed, ignoring social groups' capacity to acknowledge their problems and act in order to transform reality, making technicians responsible for standardizing life⁽¹⁴⁾.

On the other hand, we should also heed to attitudes that characterize the other extreme, which considers that only popular knowledge is valid, in which the professional uncritically adapts to the "community's cultural reality", without conflicts. This can serve to justify the use of cheap strategies, based on local resources, undermining the population's fight to conquer its rights⁽¹⁴⁾.

Another point to be addressed is that health education, by looking at disease prevention and treatment, attends to the interests of capital,

transforming the population's legitimate health needs into products (pharmaceutical and drugs industry). This evidences a contradictory mechanism, i.e. on the one hand, the medical and drugs industry emphasizes the need to consume these products in order to be healthy and, on the other, people facing social reproduction difficulties do not manage to get access to these goods⁽¹⁴⁾.

This conception is opposed to the conception of education as a collective construction of the health education process which, instead of reproducing the dominant ideology, attempts to break with "the modes of human relations through which we were programmed for work and life (as if this were the natural order of the world) (...)" This gives rise to the possibility of popular health education, in the construction of a historical subject that, recognizing him-/herself as a generic individual under development, is capable of adopting the discourse that moulds him/her to the situation of "helped", "excluded", "dispossessed" and taking an opposite position, creating a new discourse, where (s)he is constituted as a new subject. In this collectively constructed process, both professionals and the population take part (...)"⁽¹⁴⁾.

In this sense, we found the following statements in the focus groups and individual interviews: "health education means to respect the other person's culture, reality and limits", "to intervene in the life situation", "to discuss citizenship", "to question standards transmitted by the media", "to enable the population to participate in the educative process", "to advise about how to use the service". Another frequent theme was "to mobilize the population in order to seek their rights".

(...) when I started, my view of community health agent was that I would be working with families to disseminate health prevention. To get there: "you have to take this or that medication". That was my view as an agent when I started working. Today, I see it, no, differently, that besides going there and promoting health, I have to help this community to seek the rights they are offered (...). (UBS III)

These statements show that the goal of the educative process is not restricted to disease prevention, but also covers the sphere of rights and the construction of citizenship, attempting to discuss the roots of health problems in line with a political and dialogic process that allows for reflections about social reality and its transformation⁽¹⁷⁾. However, participants' discourse concentrates on life, the

neighborhood and consumption. The relations between health and work that actually determine forms of living are not addressed.

Anyway, in this perspective, earlier experiences are taken into account and the population participates actively in the educative process, in line with emancipatory education⁽¹⁸⁾. The counter-ideological character of this education is also verified, to the extent that it opposes the standards transmitted by the media with respect to "what one should do to be healthy".

Thus, we observe that the theoretical activity (education, health and health education conceptions) that guides the CHA's praxis is contradictory, sometimes progressive, transforming the dominant order and contesting the reality of social inequality, sometimes displaying predominantly conservative characteristics, in response to the interests of capital and reproducing dominant ideology.

Praxis: what community health agents do

The nature of agents' practical activity accompanied the oscillation in theoretical activity, sometimes appearing as creative and sometimes as imitative praxis. The latter predominated, as shown by the activities agents mentioned in the focus groups as well as in individual interviews, in which they reported daily work situations.

The practices that characterize a creative praxis appeared in the following themes: "doing health education means to broaden the service's view on the population's health needs", "doing health education means realizing intersectorial actions", "doing health education means being a reference point to transform the health situation" and "doing health education means having leadership to transform reality".

We (...) are the leaders there in the community, because the association itself does not participate in many things that are happening there, in the Butantã region... (...) Sometimes, we take part in meetings the residents' association sometimes doesn't even know about, and they should be, it is important, and they aren't. (...) I really see us occupying this part of leadership in the community ...because, in my view, we see to the environment, we see to children's education, to adolescents... to improve the community, we contact zoonoses because of the rats, the municipal government, everything ... We see to everything ... The association just has the name ... (UBS IV).

In this context, the agents attempted to expand the essentially curative practices, with a view

to including strategies to demonstrate displeasure and opposition towards the marginal living situation of the residents in the areas they attend. Hence, they often recovered their leading role in mobilization processes, as the curriculum of most agents in this study contained some form of engagement in groups and associations.

The proposed transformations abided by the sphere of living conditions, without any statements that actually attempted to contest the social structure. Thus, the agents' praxis does not seem to constitute a political, but merely a productive activity. "Hence, productive praxis is the fundamental praxis because, in it, man does not only produce a human or humanized world, in the sense of a world with objects that satisfy human needs and can only be produced to the extent that human goals or projects are expressed in them, but man also produces himself, forms or transforms himself (...). [Then], social praxis is the group or social class activity that leads to transformations in the organization and direction of society, or to certain changes through the State's activity. This form of praxis is actual political activity"⁽⁹⁾.

This observation reveals to be coherent with discussions by other authors⁽¹⁹⁾ who, in analyzing the character of the educative process to train nursing auxiliaries through the Large Scale Project, also found, on the one hand, emphasis on the technical character of pedagogical training and, on the other, limited political comprehension of the educative process.

Production-oriented praxis is often restricted to the realization of tasks, characterizing an imitative praxis that, in this study, corresponded to the practical activities evidenced by discourse in the focal groups, stating that "doing health education means being the health unit's eyes in the community", "doing health education is a life mission to help the other", "doing health education means hiding the service's limitations".

And, these days, we are hiding the limitations here at the unit, everything that's necessary "will happen", you see? When some administrative work is needed, making an envelope, instead of the technical assistant who makes twice as much money as we do, we are doing his work, he leaves us there at the desk to go for a walk, read a magazine while you attend the public, if you do something wrong it's 'because the agent did it'. (UBS I)

Imitative praxis was also quite present in reports about the situations agents experienced, showing that interventions were aimed at disease prevention and treatment in the individual or family

context, and that even conflict solving proposals were permeated by moralizing actions, using convincing and frightening strategies.

Thus, a large part of agents' activities seems to be instrumental, constituting an imitative practice in which the subject acts on reality by repeating tasks in order to adapt to this reality. Besides making up for service limitations, these tasks can be summed up as "bringing and taking" information from the community to the BHU and vice-versa, which correspond to a large part of agents' work. This was also found in another study⁽²⁰⁾, which observed that a considerable part of agents' work is to "take messages", such as appointment dates, to the population.

Moreover, practical activities also have a messianic character of helping other people, explaining the ideological nature of the theoretical activity they are based on. We also found imitative praxis when agents do not intentionalize the goal of their work, a consequence of the social and technical division that is characteristic of alienation. Thus, agents feel powerless when they assume the responsibility of attending to all community demands. Without knowing how to cope with this situation, the CHA use convincing and frightening strategies that condition the population to follow their advice.

FINAL CONSIDERATIONS

We found that agents' practice as well as the underlying theoretical activity possess contradictory characteristics, varying between more transformative and more conservative characteristics. The latter predominated, represented by the prescriptive conceptions of health education and by imitative praxis.

However, some agents manage to accomplish creative praxis to the extent that they illuminate their practices with theoretical conceptions that go beyond the technical pole and, therefore, exceed the biomedical character of health and constitute the foundations for actions that transform the health reality, even if in the consumption sphere.

The overcoming of imitative praxis towards creative praxis can be achieved by qualifying the agents - by training courses as well as by in-service supervision. Qualification can act on education, health and health education conceptions according to the collective health reference framework, with a view to equipping subjects for social practice based on historical reality. This benefits its contestation as, although education is not a structuring element of production relations, it is manifested as a superstructural component, capable of equipping the *subordinate classes* to understand the determinants of the health-disease process. Thus, practical activity is no longer the mere repetition of tasks, but becomes an educative principle from the perspective of a transformative praxis.

It should be emphasized that the task of qualifying agents fundamentally depends on the concretization of the Single Health System into care models that overcome the tricks of alienation in work. In other words, training should also include those responsible for improving the health workforce in general and the agents in particular. Thus, imitative praxis could be overcome, moving towards creative praxis, by qualifying all health professionals' work, improving the conceptions and operative knowledge - about education, health and health education, from a collective health perspective - that illuminate the cutting of the object and instrumentalize practice, in order to support social groups in the process of transforming health reality and constructing *full citizenship*.

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