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# Bond and autonomy of the oral health practice in the Family Health Program

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## ABSTRACT

**OBJECTIVE:** To understand the establishment of bond in the construction of autonomy of the subjects who generate the practices of oral health in the Family Health Program.

**METHODOLOGICAL PROCEDURES:** A critical reflexive approach was undertaken in this qualitative study carried out in Alagoinhas (Northeastern Brazil).

**ANALYSIS OF RESULTS:** Interviewees taken care of by the oral health team of the Program point out their problems and the treatment they want. A line of tension is established that will define the service as welcoming, binding and will contribute towards enhancing the autonomy of those seeking oral health services. However, negotiation concerning the treatment that will be implemented, between those seeking and providing it, is fundamental. Establishing a bond made it possible for negotiation to lead to a consensus concerning necessities and responsibilities, impeding the therapeutic act from being centered on the health care worker, allowing it to ensue according to the desire of the person seeking care.

**CONCLUSIONS:** Bond maintains a close relationship with the capacity of the other to become an active subject in decision making with regard to his/her life. It allows subjects to strive towards their potentialities, favoring the reciprocity of experiences and the construction of therapeutic acts for which they are co-responsible. Oral health practice based on relational pillars needs to foster bond, making those that seek care autonomous and amplifying care.

**DESCRIPTORS:** Personal Autonomy. Health Education, Dental. Family Health Program. Health Knowledge, Attitudes, Practice. Qualitative Research.

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## INTRODUCTION

In order to understand the context within which health policies are developed it is essential to analyze the conflicts established between subjects involved in the concrete field of social praxis. Therefore, it becomes necessary to establish interfaces that reveal the nuances of health practices within the social, economic, political and ideological context within which they are carried out, keeping in mind that this context is dynamic, being engendered historically.

The bond established between the health professional and the person seeking his/her assistance may be the tool which makes it possible for an exchange of technical and popular, scientific and empirical, objective and subjective knowledge to take place, converging towards the concretization of therapeutic acts. These acts are also shaped by the subtleties of each collective body and each individual, giving rise to other meanings of integral health.

Campos<sup>2</sup> analyzes the bond as a therapeutic resource, being therefore an integral part of the clinic in a broader sense, that is, “(...) overcoming alienation, fragmentation and biologically oriented technicism (...)”. He suggests, furthermore, “(...) that in order for a positive bond to be established, groups should believe that the health team has some potential, some capacity to resolve health problems. And the team should welcome the demands of those people and organizations who seek their services. The team should uphold the conviction that if those who seek care are supported by them, they will be able to participate in the struggle to overcome adverse conditions. Otherwise, a tendency to establish a paternalistic pattern of bonding, based simultaneously on both trust and distrust will ensue. Belief is fundamental; but so is the recognition that without external support, people will not transform themselves and their context.”

Autonomy, in turn, is constituted by the substitution of pleasure obtained from the object for the pleasure of representation in the process of constituting autonomous, human subjects, capable of self-awareness and awareness of the other in his/her individual and collective dimensions, permeated by creativity and active solidarity.<sup>4</sup>

The point of departure for comprehending the practice of oral health in Brazil as an object of discussion should be social intervention. Although oral health actions undertaken in Brazil are considered among the most advanced in the world, in terms of human resources and available technology, they convey a paradox, being defined by Garrafa & Moysés<sup>6</sup> as “technically laudable, scientifically debatable and socially chaotic”.

Thus, it may be stated that, on one hand, oral health produces technology and develops complex and onerous clinical procedures and, on the other, co-exists with oral health problems – such as caries and periodontal disease. Instruments for controlling and curing these disorders have already been developed and are well-known, yet they continue to plague a large portion of the population, mainly those who are more deprived.

This situation brings forth a reflection on the education of dental surgeons. Both public and private universities have trained the dentist to exercise his profession in a liberalizing logic that overestimates the value of individual cure, often disregarding public and collective health actions. Narvai<sup>10</sup> stresses that “the majority of Brazilian public dental services reproduce, in a mechanical and acritical fashion, nuclear elements of the model of dentistry in the private sector of health services”. The professional trained to treat only the disorder limits his practice for he does not perceive anything beyond the mouth and, because he perceives it as isolated from the body and from a dynamic territory, he aborts other therapeutic possibilities. By focusing actions on caring

for illness, the dentist specializes in treatments which are more and more complex, withdrawing himself once again from the real meaning of health practices which are directed towards the human being and not simply to a disease or its consequences.

According to Ceccim & Carvalho,<sup>5</sup> “the increase in the number of specializations does not guarantee satisfaction on the part of the population with respect to care, to the services or to the relationship established with health professionals themselves. One of the factors that contribute to the lack of satisfaction is precisely the fragile character of education concerning the *Sistema Único de Saúde* (SUS –Brazilian Health System), during the first years of dentistry school, and the fact that the terms of integral care are not a criterion for stipulating health practices (...) Integral care is still an object of rhetoric and not of education”.

That being so, there is a need to (de)construct an entire practice geared towards disease and to (re)construct in its place a model of oral health that no longer excludes a significant portion of the population from its services, obstructing its capacity to resolve problems, in order to guarantee dignity and integral care both to the people seeking oral health services and to the dental surgeon himself.<sup>11</sup> Considering that the construction of a model of oral health care should be in consonance with Brazil’s expanded concept of health, the objective of the present study was to understand the establishment of bonds and their role in the construction of the autonomy of the subjects that engender oral health practices within the *Programa Saúde da Família* (PSF – Family Health Program).

## METHODOLOGICAL PROCEDURES

Qualitative research was conducted by means of a critical-reflexive approach to oral health practice. Three family health units in Alagoinhas (Northeastern Brazil), in which oral health teams were working, constituted the sites studied.

Research techniques were semi-structured interviews and systematic observation of oral health practice. The subjects of this investigation were 17 people who were active at the research sites during the period between 2001 and 2004. These subjects were distributed in three groups of representations: group I (dental surgeons and dental aides) – 6; group II (other health workers – 6); group III (people seeking oral health care – 5).

The interviews and observations of oral health practice were guided by topics for discussion that covered the following issues: 1) how the oral health team approached people who sought care when these were being attended; 2) the dialogical and pedagogical relation established between the health professional and the person seeking care (how are speech, comprehension,

respect and commitment put in practice); 3) participation of the community in planning activities (making appointments, establishing criteria for consultations, procedures, priorities); 4) criteria for undertaking a clinical procedure (need/desire of the person seeking oral health care/ of the professional, or material dependence/equipment available); and 5) how the person seeking oral health care is received at the Family Health Unit (information, elucidations, waiting time, language usage, accommodations, amongst other things). Data was collected in the first semester of 2004.

Analysis of the data was based on Minayo's dialectic-hermeneutic model.<sup>9</sup> Analysis of the interview groups was conducted by discussing convergences and divergences and articulating these by means of the theoretical framework aforementioned.

The research project was approved by the Ethics Committee of the Universidade Estadual de Feira de Santana.

## ANALYSIS OF RESULTS

Health is not exclusively the result of the consolidated practice of biomedicine. Likewise, oral health is not exclusively a consequence of odontological interventions, but is related to biological, emotional, religious, cultural and economic aspects that require semiotic means that make the diffusion of care possible. Health practices are, in principle, social constructions originating tacitly from different groups and that are accepted by subjects by means of the elements that are present in daily life and being expressed by means of language codes and behaviours.<sup>1</sup>

The discourses of dental surgeons and dental aides converge by means of the following representation: *"on the day-to-day bases, in the manner of attending people, we try to attend people in the most affectionate way possible, affectionate is the word (...) so that I try to maintain the bond, to discuss problems, try to obtain the community's support (...)"* (Group I).

However, it was noted that people who seek oral health arrive at the services with an expectation with respect to care, clearly expressing what they want. At this moment a "line of tension"<sup>12</sup> establishes itself and it will define if the service will be welcoming, will establish bonds and will contribute towards upholding and increasing the autonomy of those who seek care. People's discourses revealed that, even though they signaled their demands and/or needs, those that sought the services had to negotiate with respect to their treatment. In this respect, of course, the limits that surround oral health practices must also be taken into consideration. These limits include: the lack of available material to conduct the procedure being demanded, technical capacity or the dentist's preference

with respect to the realization of the procedure, the dentist's lack of interest in resolving the problem, and the lack of correspondence between the client's need and the possibility of satisfying it at the hierarchical level of the health unit.

The establishment of a bond allows negotiation to proceed towards a consensus with respect to needs and responsibilities. It impedes the therapeutic act from being centered on the professional, but, even so, does not transform it into the pure manifestation of the desire expressed by those seeking assistance. The existence of the bond makes interaction between both treatment propositions obligatory in the quest for the best conduct of care.

It was found that the flow was organized having the complaint presented by the person seeking assistance as its point of departure. It was the latter who chose beforehand the procedure that he/she desired. Fragmentation occurred in the process of organizing the demand due to the fact that it was conditioned by supply as well as by the professional available. Contradictions are salient, as, for example, when the dental surgeon decides to attend to the anxieties of the community with respect to dental extraction. The professional reported weariness due to constant confrontations with those who seek the service, demanding this mutilating treatment. He thus decides to submit his practice to external desires, even though he does so reluctantly. *"(...) so by December, I was so tired, so very tired that I said: 'look, don't they want extractions?. So extractions it will be!'. So, in December, the only thing I did was extractions"* (Group I).

Ambiguity is perceived, since listening to the other does not signify yielding passively to their command. The strategy chosen by the worker does not construct autonomy, for it does not create a space for negotiations and for establishing pacts in which the demands of those seeking care can be contextualized and redefined. Disconsidering this potential may imply in a lack of bonding, and simply yielding to a community's desires may represent a way of not assuming responsibility for the challenges of transformation that arise in the daily practice of oral health.

Preferences with respect to exodontia among those who seek oral health care are historical constructions, associations that are imbedded in collective cognition, the result of practices developed in relation to oral health during many years. Those seeking oral health, due to the difficulty they confront in accessing the services and/or the limited nature of resolutions they encounter, end up opting for treatments that will put an end to their suffering, that will guarantee that this problem will not repeat itself, at least not with respect to that particular tooth.

However, other statements reiterate the issue of “doing what the person seeking care demands”, by means of a negotiation. By allowing the other to express his demands and arguing with him/her in the attempt to achieve the best therapy, the dental surgeon inscribes the element of the bond in the clinical act and makes autonomy effective. One of the people seeking care synthesized this idea in the following terms: “*Well I think its done not the way I want, but within my need and the way he explains it to me, I believe the problem is resolved, because I come here with a problem, he explains what is happening, gives me the medication, advises me to do something and I believe that this corresponds (to what I need)*” (Group III)

One must not confuse the meanings of risk evaluation<sup>2</sup> with screening conducted in some family health units when an appointment is being scheduled. What is being discussed is not individual choices or those made by administrative agents, dental aides or community health agents during reception, even though these should signal the identification of specific demands. The definition of priorities should be based on epidemiological and clinical criteria upheld within the field and by the nucleus of health workers’ knowledge. However, this definition should be legitimized by the community, that is, even when an organization within the family health unit is based on scientific criteria, it will only become effective by means of the collective construction of this operational tactic.

The perspective of cure or of alleviating suffering depends primarily on the construction of a person endowed with the autonomy to better comprehend and administer his/her own needs. Other fields of knowledge have yet to be mobilized so they can act upon the relational processes and consubstantiate themselves in welcoming those who seek care, making them accountable for and committed to that care and at the same time operate the existing social bonds.

Interviews revealed the existence of conflicts generated in the dynamics of oral health practice, due to the proportion of one dental health team for two family health teams. Since there is only one dental clinic available for both family health teams, one of the family health units receives a flow of patients from the other area. Thus one of the family health units functions with two forms of registration. According to statements, this has led to misunderstandings and distrust, for generally those people who do not have a dental clinic in their area feel disparaged, as indicated in the following statement:

*“I had to make an arrangement, because there wasn’t even a clinic at the other unit. So people came here from over there and, although its nearby, this created several inconveniences. The issue of a person being attended at a unit other than her own and by professionals that aren’t the ones with which she or he is familiar, the*

*issue of dispute, for people from that unit always felt they were being left aside because of the people from over here. (...)* (Group II).

Another relevant structure in the statements was the sensation of not belonging that people from the other unit felt when they had to seek care at a service where they were not familiar with the health workers, with the exception of the members of the oral health team. Perhaps the sensation of estrangement, besides difficulties with respect to access, justify the constant faults at clinic consultations among those who came from the family health unit that didn’t have an oral health clinic.

Challenges imposed by organizational structure congregate the need for bonding as an agent that promotes relations fragmented during the oral health team’s work process. By enlarging the scope of practice beyond the family health care unit, the Family Health Program propitiates the interlacing of relations and affects between health workers and the community.

Strategies developed by the oral health teams (home visits, group activities in schools and community centers) have converged towards the establishment of bonds and have reinforced the community’s autonomy with respect to self-care and the exchange of experiences. A structure that appeared in several interviews was the construction of the subject’s autonomy once a bond had been established. Therefore, decentralization of oral health care, at a time when other subjects (dental aides, teachers and the family) become involved with the process of care, generates a dissemination of actions and leads the clinic to become more democratic.<sup>2,3</sup> This identification is stressed by an informant: “*(...) not just me and the community agent, everything represents bonding, him, the school, the family, everything has a bond. It’s like this, a cycle, each one has to play his role so as to develop his work. By ourselves we can’t do anything. The Family Health Program has this characteristic. Participation!*” (Group I)

One of the prominent subjects in the oral health care practices in the municipality was the community health care agent. He developed his actions in the areas serviced by the health unit, acting in direct relation to the families, by means of the household visits. The role of the community health care agent was relevant in creating the bond with the community. However, what defines the quality of the activities promoted by these subjects is their capacity to observe, interact and to get to know the people in their area.

The principal oral health activities undertaken by community health agents were: collective procedures at the schools, talks in the community, fluoride application, ludic activities, meetings, scheduling appointments, household visits, and detection of families

or individuals with greater vulnerability – organic, subjective or social. This entire apparatus of activities increased considerably the responsibilities of these workers, demanding a policy of permanent education so that they can exercise their jobs in a safe and efficient manner.

The scene seized by the health community agents in the municipality was of great prominence, with strong political representation and broad social insertion. Thus, the agents had become a critical mass, having the concrete potential for maintaining or participating in the process of instituting a health care model that has integral assistance as its central axis.

The oral health teams also made household calls; all teams reserved a weekly shift for this purpose. The criteria for household visits should not be their compulsory character. They only make sense if they are based on an explicit necessity, and paying daily visits to the residence is a role attributed to the communitarian health agent. Optimizing human health resources is necessary; therefore it is not admissible that a worker should conduct a visit without knowing why or for what purpose he will be doing this.<sup>7</sup>

The house call should not be viewed as a task done simply for purposes of registration at the end of the month. The household visit is understood as a clinical and pedagogical instrument within the actions of the Family Health Program: “(...) *at the home visits we have a very positive response (...) we can verify that the community really appreciates the dentist's house call, (...) they asked us to continue doing these household visits precisely because of the large demand that we have here at this service and the difficulty they have in coming to the unit: people that are handicapped, the elderly, many people who are bedridden*”. (Group I)

The oral health teams conduct different activities that have the potential of establishing a bond and co-producing autonomy. However, the observations made during research made it clear that collective actions gave priority to oral pathologies or hygiene techniques and that their perspective was mainly preventive in its focus. So activities outside the clinic should be devised to set off changes, that is, these teams must discuss issues of citizenship, health and socioeconomic policies, as a means of strengthening the bond, constructing autonomy and arousing people to become co-responsible for confronting their communities' problems.

Another aspect presented itself as one that goes against the success of oral health practices within the Unified Health System. One of the interviewees stated that the Family Health Program was a privileged site for innovations and that it had the potential to transform the model of care. However, he stressed that some health workers did not identify with this social project, and represented a limitation with respect to the process of

advancement: “(...) *one difficulty is the cultural issue of the people who work in the program. We know many people who have made some savings by working in the program and we end up meeting professionals who are not appropriate for the program (...) but, many professionals become disheartened, due to problems of an entirely different nature, such as management, salaries and everything else.*” (Group I)

Consequently, managers should propose policies that identify workers with the appropriate profile and that are committed to the program, assuming responsibility for its success. Managers should also present strategies to maintain these workers in the municipality the longest time possible.

## FINAL CONSIDERATIONS

It is possible to change oral health practice by reorganizing the work process, including light technologies as mediators of the encounters between health workers among themselves and with those who seek assistance. These practices should be defined by the territory of necessities and by demands presented by the population seeking health care and it should be delimited by the various forms of popular and technical knowledge available.

Oral health care has historical roots in the resolution of problems concerning health and illness of individuals. It is based on curative practices, on compartmentalized knowledge and on the fragmentation of the therapeutic act. The present study's contribution is the proposition that health should be conceived not as the absence of illness, but on oral health produced to make the subject-person seeking care more autonomous, capable of developing self – care and also of becoming other people's therapists.

The bond holds a close relation to the other's capacity to assume the condition of being an active subject in decisions concerning his/her life. It is, therefore, the disposition that leads the subjects (workers and people seeking care) to an encounter with their potentials, for it favors reciprocity of experiences and, thus, lays the groundwork for the construction of co-authored therapeutic acts for which responsibilities are shared.

Santos et al<sup>12</sup> mapped out the lines of tension that are processed in the encounter between dentists and those who seek their care and signaled that the result of the intervention may be “prevention, cure or health rehabilitation or, on the contrary, a iatrogenic disorder or the maintenance or aggravation of illness”.

In this sense, Campos<sup>2</sup> stresses that “the role of the health professional is to act upon the other that puts him/herself under our care, but it also implies helping him/her to help him/herself, stimulating his/her capacity to confront problems, due to concrete life conditions”.

Welcoming and bonding actions, it is believed, carry a substrate which has the capacity of feeding practices, making them efficacious and efficient. They edify affective values and those of respect towards the other's life, making it possible for traditional practices (curative and preventive) to gain a new dimension, regulated by the collective interest, transposing the prescriptive character that have guided these actions in the past.

This perception is described by Schraiber & Mendes-Gonçalves<sup>13</sup> "the individual that feels sick or who is suffering sees a way out: he assumes that there is a desired correction for his problem and that there are means for putting it into practice. The result of interventions upon any of these privations is recognized as a necessity, transforming the interventions themselves into necessities. Besides, if the starting point is the solution foreseen for any of these privations – a forecast that is possible for the individual because he has already seen it being efficacious and sufficient for others in society – each person knows what type of service to seek: if it is or is not a health care service; if it is this or that modality of care within the health care services".

Campos<sup>2</sup> complements these ideas, when discussing how the definitions of priorities can be a resource utilized to guarantee the quality of a clinic and defends the notion that "to practice clinical medicine is to evaluate risks and, based on this, to intervene with specific therapeutic resources, according to each case and its specific phase: medicine, health education, household visits, dietary, existential and group counseling... A primary health care service that attends everyone who seeks its assistance and that is incapable of making distinctions among its patients, does not carry out good quality clinical care".

Even when difficulties are being faced, such as a large demand and scarce resources,<sup>2</sup> it is necessary to fortify bonds. Campos & Campos,<sup>3</sup> in turn alert us that in order to work in benefit of the production of health, a new posture is required of people as citizens, teachers and/or members of health care teams; organic commitment is required, allowing one to get involved by the

dynamics of health care. The redemption of the individual and collective subjects' autonomy is, therefore, vital. It promotes and enhances the intrinsic potential of the community and of the individual, whether this person is seeking care or is a health care worker, to share knowledge and to make choices. It is also essential in the co-productive dimension, in the sense of perceiving if the daily practices are emancipating the subjects involved and whether these are assuming co-responsibility for their actions. Otherwise, citizens under tutelage are created, people who are dependent on others for the choices that are made on their behalf. The authors believe that it is the role of health workers to promote and to potentialize the coefficient of autonomy of the distinct subjects, both individual and collective, so as to propitiate sustainable and perpetual healthy life conditions.

The study indicates that community health agents were fundamental subjects in the process of generating a relationship based on trust and complicity that extends itself to the other members of the health care team, potentializing the bonds with those that seek the services for care, as well as the latter's autonomy as they feel welcomed and supported by those that care for them. The health care agents are, therefore, natural carriers of the bond with the community, capable of contributing towards the autonomy of those that seek the health care unit for assistance. In the household visits, these agents stimulate the residents to administer their health processes, by fortifying self-care and self-perception.<sup>8</sup>

Finally, bonds and autonomy interlace, construct themselves and promote each other, in a reciprocal relationship that takes place in the interstices of social practices – in this case in the "womb" of health and, therefore, of oral health.<sup>11</sup>

In this manner, oral health practice based on the pillars of relationships, needs an amalgam that links together, tightening bonds and liberating the other's potential, making the person seeking care more autonomous and enlarging the spectrum of care.

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