ORIGINAL RESEARCH

Medical Students and Community in Southern Brazil: An Experience in Reciprocal Empowerment

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Abstract

Brazil's Unified Health System (Sistema Único de Saúde, SUS) is rooted in the 1988 Citizen's Constitution. Universal health reforms, inspired by Freire's legacy of popular education, embody the struggle within Brazilian society against authoritarianism and inequality, and for democratization. "*Controle social*" (the participation of the public in management and oversight) is a key principle governing the system. It is a broad term that encompasses government accountability to communities, health self-agency, community participation, and local empowerment. *Controle sociale* is institutionalized through Health Councils, which are set up at the local, municipal, state, and national levels. This article examines the experiences of the Health Education League, a project that brought together medical students from the Federal University of Rio Grande and residents of the Barra fishing community, and used Freirean principles to co-construct knowledge and empowerment in health. It describes the community's efforts to establish a participatory local Health Council as a means of improving primary care and embedding the right to health. These efforts at empowerment succeeded in establishing a Strategic Family Health Basic Health Unit in the community, however *controle social* through a local Health Council has yet to be fully attained. In this case, popular education represented a qualitative key that "unlocked both sides of the door" to reciprocally empower communities and student health practitioners.

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Submitted: July 16, 2015
Revised: September 25, 2015
Accepted: September 26. 2015

Conflict of interest: None

Peer-reviewed: Yes

Universal health reform and the principles of *controle social* and empowerment

Health reform in Brazil has been recognized for its strongly participatory aspect. Since the 1970s, health reforms have been driven by strong social movements for public health, led by the Sanitary Movement.[1] Brazil's struggle was part of the wider, global movement of civil society, health professionals, and administrative reformers that culminated in the 1978 Alma Ata Declaration which demanded global health reforms focused on Primary Health Care with quality, equity and accessibility.[2] Brazil's 8th National Health Conference (1986) laid the foundation for a universal health system based on the right to health and democratic principles. The 1988 Citizens Constitution and 1990 Organic Health Law (*Lei Orgânica de Saúde*) established the new Unified Health System (Sistema Único de Saúde, SUS), based on the principle that health was a citizen's right and the state's duty.[3] Health system reform was integral to the political and societal democratization that followed the period of dictatorship (1964-1985), introducing a combination of universal social policies, decentralization and citizen participation.[4]

SUS can be described as a publicly funded, rights-based health system embodying the principles of universality, integration, and *controle social*.[5,6] Universality is expressed in solidarity-based arrangements for central funding and universal coverage. Integration is realized in two ways: the system functions as a whole, containing levels of organization spanning from local to national; and seeing people holistically, including their individual characteristics, their family, their community, and their social-economic context. "*Controle social"* is more difficult to translate. Broadly speaking, it encompasses accountability in relation to communities, health self-agency, community participation, and empowerment. This plurality of meanings is key to understanding health empowerment and participation. Empowerment is a complex concept, embracing values, knowledge, behaviour and relationships.[7] In the health context, empowerment involves educational objectives concerning the reinforcement or development of general psychosocial skills and patient-centeredness. It is based on experiential learning, and requires continuous, self-involving relationships on the part of both the healthcare provider and the patient.[8]

Reflecting the importance of primary care in Brazil's health system reform, the initial phase of SUS implementation began by creating Basic Health Units (BHU). Early BHUs tended to reinforce professional medical specialisations (gynecologists, pediatricians, clinicians) instead of devolving "*controle social*" over care to the community. The focus was on bringing together clinical specialists, not on prioritizing the individual and their family, community, and context. "Traditional" BHUs provided decentralized medical assistance at the community level, but failed to empower, because individuals tend to be treated as isolated patients, in a fragmented and decontextualized manner.[9]

The BHU model began to change in 1994, with the introduction of the Family Health Programme focused on primary health care. "Traditional" BHUs were replaced by "Strategic Family Health" BHUs[9] which offered new ways of working that were centered on families in their community context, not merely on individual patients. This approach emphasized preventive approaches and enabled better social participation, facilitated by community health workers.[10]

The centrality of *controle social*

The principle of *controle social* in the Brazilian SUS reflects broader processes of democratization. The 1990 Organic Health Law laid the foundation for the creation of the SUS and institutionalized both Health Councils and Health Conferences. Laws 8080 and 8142[11] established the concept of *controle social* as a first step towards making the right to health into a reality. Health Councils operate at four levels, (or spheres) of power: the local, municipal, state, and national.

Local Health Councils provide the institutional structure for local participation and controle social of the BHU's (both "traditional" and Strategic Family Health). Local Health Councils are composed of civil society representatives (50%), municipal health managers (25%), and SUS health workers (25%).[12] However, the rules are flexible; local Health Councils can be entirely constituted by community members when there are insufficient municipal health managers or SUS workers. Today, there are around 28,000 Local Health Councils throughout Brazil,[6] and they are widely considered to be a major participatory innovation, sparking considerable international interest as an example of decentralized, participatory health governance.[5] Health Councils are legally empowered to inspect public accounts and demand accountability, thus influencing how resources for health services are allocated.[6] Participatory health governance ensures greater adaptability of health services to particular needs within communities. For example, decisions about where a BHU should be located or the most convenient hours of service can be influenced at the local level.

Despite these participatory mechanisms, the overall structure of the local Health Councils remains somewhat vertical. The decentralization of resources to the BHUs does not exactly match the governance structure of local Health Councils. Gaps remain between the communities and their health system that can still be filled with other routes of empowerment.

The role of Popular Education

Popular education has contributed substantially to processes of *controle social*, participation and empowerment. Up until the 1970s, health education in Brazil reflected predominantly elite, technocratic priorities for population health.[13] Public health measures were implemented through coercive, rather than democratic or participatory modes of action. The authoritarianism and extreme social divisions of the military period (1964-85) paradoxically created the conditions for popular resistance to emerge.[14] Prioritization of private medical services, especially hospitals, left health education and promotion activities with little significant space.[13] The military government concentrated on economic growth, relegating social policies to the background. Community participation in health during this period was limited to mobilizing the population to comply with limited public health initiatives.[13] It failed to address the overall trends of growing health inequity and exclusion. There were stark contrasts between wealthier urban consumers who could afford out-of-pocket charges or formal workers who were protected by labor unions, and the rest of the population which included the large informal sector, the unemployed, and the rural poor. These latter groups were forced to rely on charity care.[15] The contrasts were starkest in the rural areas. Where basic medical services existed, one could argue that the local community was involved but without empowerment.

Popular education, systematized by Paulo Freire, provided a guide for rethinking the relationship between intellectuals and the popular classes.[16] The process of critical reflection gradually led to forms of popular resistance and the desire for liberation from authoritarian forms of power and dictatorship.[13,14,16] Many health professionals had become dissatisfied with exclusionary, commodified and routinized practices and joined with popular forces.[14] A dialogue became possible between popular and academic understandings and experiences. There was a break with authoritarian and normative health education and a move towards oppositional and critical modes of education and consciousness. Brandão contends: "Popular Education does not aim to create educated subaltern subjects: subjects cleaned, polished, literate, drinking boiled water, eating soy flour, and using septic tanks."[17] Instead, it aims to create active citizens who are not simply obedient, but who become critical, reflexive, and capable of becoming agents of change. In the empowerment process both patients and professionals are changed; the professionals are offered the chance to unlearn being in control.[8]

In the 1980s, Brazil experienced major social and economic crises. Living conditions worsened as unemployment and malnutrition increased. Social protections were cut back and the health of the population suffered.[13] Social movements responded by demanding the democratization of health services and health reform. This activism culminated in the 1986 8th National Health Conference, the proclamation of a new republic under a civilian president and a new constitution.

Popular education, embodying Freirean principles of critical consciousness, resistance, and mobilization, became an important tool for building and expanding community participation in this new context.[13] This was not a simple process. Nonetheless, the strong history of social participation within the democratic movement already had been embedded within a struggle between authoritarian-technocratic and critical, participatory elements who saw self-determination as a key principle.[8] Tensions remain today between social participation as conceived by Freirean popular education and the largely top-down public health events and campaigns conducted by state and municipal departments of health.[14]

Methodology

The paper examines the results of a student initiative at the Federal University of Rio Grande (Universidade Federal do Rio Grande, FURG). Thirty medical students (including author MF) formed the Health Education League. They subsequently created a dialogic partnership with members of the Barra community. This article reports on the field activities that took place between March 2013 and December 2014. These activities involved participant observation in the community, as well as formal and informal group reflection conducted by the Health Education League. The partnership produced systematic documentation and reflections on their expe-

riences, including photographs, videos, and scientific works, jointly created by the students and community members.[18] This article draws upon these qualitatively rich, reflective field materials, in combination with a review of secondary materials (research articles, policy documents and published reports), identified from Scopus and Web of Science databases using 'health empowerment' as the search term.

Ethics

Educational field experiences and reviews of educational experiences are considered exempt by the relevant institution (FURG).

Results

Medical Education and the Health Education League

In 2010, thirty first-year medical students at the Federal University of Rio Grande (Universidade Federal do Rio Grande, UFRG) founded the Health Education League. Their starting point and motivation was a sense of dissatisfaction with the overly technical and dehumanizing aspects of a medical education that treated people as distant social subjects, detached from local realities.

The students wanted to change the paradigm of health education. They wanted to work with a community to explore the possibility of knowing and interacting with different knowledges, of respecting mutual differences, and of contributing to the co-construction of knowledge about, and understandings of, health.[19] After a process of self-reflection they named the group the Health Education League. They discussed how best to approach communities and what methodologies to employ. These activities were facilitated by a professor of Family Medicine. Their first contact with a community came through the Medical Relationships module, a compulsory course in the first year medical curriculum. In August 2010, the students worked with a primary school which was part of an Integrated Child Development Center (Centro de Atenção Integrada da Criança, CAIC) adjacent to UFRG's Campus Quarter.[20] Subsequently, the group worked with a Youth and Adult Education class.[19,20] Initially, the Health Education League met with this class every two weeks to discuss and share experiences on health topics.[19-21] The Health Education League students held parallel weekly meetings to develop and deepen their own personal and theoretical perspectives. They began to work with two additional communities: the Comunidade Castelo Branco and Asylo dos Pobres.[20] Maintaining these community linkages became quite difficult as Brazil's Federal Universities staged a massive strike to protest major cuts to university funding. This strike interrupted all university activities for three months, resulting in the disintegration of the Youth and Adult Education collaboration. The Castelo Branco collaboration also fell apart.[20]

The critical reflection that students were practicing within the community settings began to have a reciprocal effect within their own group. The concepts of popular education led the students to critically reflect on their own learning processes and on medical education in general, particularly the dominance of technical and biomedical models. They began to question hospital-centered understandings of medical care and to advocate community-based knowledge of needs and rights.

As the students became more aware, the principle of *controle social* began to surface within medical education itself. Elements of reciprocal learning and the self-determining aspects of empowerment could now be discerned in a complementary set of processes occurring within communities and among the students.[8] Freire's critique of "banking education" (which sees students as empty receptacles to be filled up with knowledge) underpinned critical and resistant modes of reflection amongst the students. This, in turn, influenced their dialogue with the community groups.[22] The students noted the conceptual and practical differences between the conventional approaches to training adopted within medical schools and the concept of education for critical consciousness (*conscientização*) leading to mobilization, as proposed by Freire.[23]

The development of SUS is a huge project, requiring an enormous investment in the training of health professionals. Yet, Almeida-Filho has argued that the main limitations are not quantitative, but qualitative; the key issue is that the education of

health personnel is deformed.[15] Ideally, the SUS workforce should be composed of skilled, evidence-oriented, and well-trained professionals, who are committed to health equity. However, the profile of professionals currently working in the system does not match with this ideal.[15] Almeida-Filho's observations and our own reflections from the experiences of the Health Education League lead us to suggest that popular education could be the qualitative key that "unlocks both sides of the door," opening up a new sense of critical professionalism and health empowerment that involves both communities and students reciprocally.

Barra community background

The community of Barra is located in Rio Grande, the oldest city in the state of Rio Grande do Sul. The city has the largest port complex in southern Brazil.[24] Although the community, also known as 4ª Secção da Barra, is a well-established informal settlement, its inhabitants lack secure housing rights. The community occupies land that officially belongs to the federal state, under the jurisdiction of Rio Grande's Port Inspectorate.[25] Barra is threatened by a possible expansion of the port and its inhabitants live in constant fear of losing their homes.[18] Residents live in temporary wooden houses. They may be forced to leave, and summary demolitions have occurred.[25] The community faces an ongoing cycle of promises that they will not be moved, followed by threats and demolitions. The majority of the community subsists on commercial and artisanal fishing.[25]

The insecurity that comes with being an informal settlement affects the community's right to health and education. The threat of port expansion delays the provision of improved infrastructure, housing, and services. It is a struggle to secure any improvements.[18,25]

Until 2013, a small Traditional BHU served this community of some 5000 inhabitants. A doctor saw patients twice a week and there was a full time nurse. But the clinic lacked the complete health team available at a Strategic Family Health BHU. Such a team would include community health workers and a local Health Council, a key element for *controle social*.

In 2004, the Barra Artisans' Group (Grupo de Artesãs da Barra; GAB) undertook a significant community development initiative. GAB had emerged from an environmental education initiative sponsored by an NGO: NEMA (Núcleo de Educação e Monitoramento Ambiental), which was engaged in a Marine Turtle project along the Rio Grande do Sul coastline.[26] The NEMA project raised local community consciousness regarding marine environmental protection by combining environmental education in the schools with craft training for the pupils' mothers.[26] The women from this program went on to create GAB, a community-based initiative to supplement their fishing incomes by producing handicrafts featuring local marine species. GAB became a venue for mutual support and a space for empowerment. Women who participated in the project moved on to create additional independent small businesses. GAB enabled the Barra Community to engage in self-realization and resistance, the "will to be more" discussed by Freire.[27] The spaces it opened up enabled community members to start a dialogue about different knowledges and the construction of health knowledge.

Health empowerment of community and students

After almost six months of frequent visits to build relationships, the Health Education League began a formal project with GAB in March of 2013.[20] The Health Education League, GAB, and community members invited by GAB began weekly practical activities. After several meetings dedicated to a discussion of individual health issues such as hypertension, hypothyroidism, and workplace health, the students and community identified understanding the SUS and health rights as their top priority. They agreed to use the project to discuss and co-construct understandings of SUS, what preceded it, and current realities.[20]

The students presented and discussed with the community the 1988 Constitution, the Right to Health, and the underlying principles of SUS including *controle social* and its implementation via Local Health Councils.[20] The students and community jointly identified the main problems and challenges for implementing SUS locally. The problems concerning the traditional BHU in Barra were identified

in this discussion. The community complained about the inadequate and superficial approach, the limited provision of services (one doctor present only once a week, one nurse working almost alone in the Health Unit), the lack of infrastructure in the Health Unit, and the absence of dental care.[20]

The community suggested that an informational brochure describing the SUS and the Right to Health should be created and distributed to each household in Barra Community.[20] The resulting brochure was called "My Rights in the SUS" (*Meus Direitos no SUS*). It contained provocative questions and information, functioning as an invitation for community members to participate in the discussion about health.[18] Miranda Júnior and Floss comment that "[t]his brochure was interesting because it was a joint project that reflected what had happened in the meetings. It was very motivating for us to witness the process of consciousness raising that occurred in the community once they understood their right to health".[20]

Subsequent meetings focused on the idea of participation in relation to SUS, the principle of *controle social*, and the possibility of establishing a local Health Council for Barra. As one community member wrote: "(…) our community was without care, but we have rights and we can create a local Health Council to struggle for a better health care..."[28] The community and students decided meet with the representative of the traditional BHU in Barra. The leaders of GAB and the nurse from Barra traditional BHU met with the Rio Grande Municipal Health Council to articulate their community's health needs and to argue for the creation of a local Health Council. This would strengthen the case for the traditional BHU to be transformed into a Strategic Family BHU, offering increased services and more integrated, community-oriented care.

At the end of 2013, the Rio Grande Municipal Health Council and the Health Secretariat of Rio Grande agreed to meet with the Barra community at the Barra community center. At this meeting, the health authorities announced that the traditional BHU would be transformed into a Strategic Family BHU in 2014. The Health Education League and the community welcomed the announcement. Improved facilities would confirm the community's right to receive healthcare based on integrated primary health care. By early 2014, Barra community had a full-time doctor specialized in Family and Community Health, a pediatrician attending once in a week, and dental care.

Unfortunately, both bureaucracy and elections delayed the full transition to a Strategic Family BHU. The local Health Council has still not been formally established because the necessary members have not been appointed.

The establishment of the Strategic Family HBU was an important achievement for Barra. However this success served to block further local mobilization to secure *controle social* through an established local Health Council. The Barra community assumed that the expansion of services meant that their rights were now ensured.

Controle social: beyond participatory local Health Councils

On the surface it appears that the Strategic Family BHU and local Health Councils function within the SUS in a decentralized and democratic manner. However, the system remains too bureaucratic and vertical. On one hand, the outcome in Barra shows that it is possible for a collective political effort by community and students to deliver improved access to primary health care. Public policies can be positively impacted in the interest of health equity. On the other hand, these successful outcomes could also be seen as disempowering to the extent that the community did not vocally pursue the establishment of a local Health Council after the 2014 changes. Some feared that the practical gains would be threatened by a request for a local Health Council. The students remained similarly quiescent.

Perhaps *controle social* can have a double meaning: the power to give voice and empower, or the power to silence. The Barra case shows that the formal establishment of a local Health Council is not the only possible mechanism of *controle social*, and that other routes of empowerment are possible. The proposal to establish a local Health Council in Barra was the outcome of a community-owned process of consciousness raising and mobilization. The community was accompanied by the Health Education League of medical students, who were also en-

gaged in their own process of consciousness-raising and mobilization. Other, less-institutionalized forms of *controle social* are also possible, involving alternative forms of participatory management and accountability, working outside or alongside formal structures.

An example from rural northeast Brazil demonstrates an alternative way of challenging policy and institutionalized "*controle social*" through a participatory approach operating outside of the institutionalized Local Health Councils.[29] According to Prado: "we would not like to implement a strict policy of popular participation, we would like to use dialogue to enhance political structures."[29]

Controle social may be a concept that is ready to expand and evolve. It is already present in law and social policy, but new forms of health accountability, responsibility, and participation may emerge via a less bureaucratic approach, driven by the empowerment and agency of communities in dialogue with future health practitioners, current practitioners, and the authorities. Today, there is a dualism of integration and *controle social* within the SUS. On one hand, the essential legacy of the Sanitary Movement endures in the vision of a singular, state-controlled health system that is able to penetrate and structure, in an organized manner, the various levels of social life involved in the processes of illness and healing.[30] However, this logic is not easily adapted to the community level. Communities do not organize themselves in such a logical, uni-linear manner. Instead, they develop variable and emergent social processes, making empowerment highly dependent on the particular context.[7] Communities may articulate popular demands, adapted to their own needs and realities; they may not necessarily require the formal institution of a health council to secure participation and *controle social*. It is important that *controle social* is not constructed in a monolithic manner as this may cause health system reforms to fail to meet the rights-based tests of inclusivity and adaptability. Brazil's SUS should remain open to *controle social* defined in ways that do not foreclose new possibilities of inclusion, articulated by different struggles at the grassroots.

Conclusion: The double key of empowerment

In conclusion, we suggest that the Barra community's experience with popular education provides insights into empowerment as an integral element for *controle social*. The concept of health empowerment has its origins in popular education,[31] and popular education provides a qualitative key that unlocks barriers to participation for both the community and for health professionals.

When considering how Brazil's SUS should develop, we might bear in mind the importance of equality and autonomy within the context of empowerment. This highlights the importance of "asking why," and self-determination, not merely compliance.[31,32] We should recall Baxi's critique of development as a process within which *developers* monopolize the power to decide what is "good" for *developees*.[33] This top-down approach fails to understand how *controle social* may evolve through popular resistance and self-realization. *Controle social* means more than the institutionalization of formal representative structures or the mobilization of the population to comply with public health campaigns. It involves emergent identities that challenge authority, and use dialogue to check and diversify the way that power works within the health system.

The oppositional and critical elements of *controle social* challenge and contradict understandings of integration and universality that leave no room for critique. Does the principle of universality dictate that a health system should be characterized by a monoculture? Can universality accommodate differences expressed at community level? Can a health system remain true to the principle of integration, while reflecting and respecting the perspectives of both society and its diverse peoples? From a right to health perspective, the principles of availability and accessibility must be accompanied by those of adaptability and quality.[34] The Health Education League and Barra community's experience indicates that dialogue can drive transformation from the medicalized view of the "patient" (as Sen puts it) towards active participation of *agents* with the capacity to engage in the social structure.[35]

"Becoming health agents together" invokes Freire's concept of the "impatient patient."[36] This article reflects on the experiences of "impatient stu-

dents" as "impatient professionals" attempting to enact *controle social* in more egalitarian, dialogic ways. By enabling reforms of health education and the health system that go beyond formal representative structures, SUS is evolving according to its own principles, vindicating the right to health though the reciprocal empowerment of all agents involved.

Acknowledgments

The authors would like to thank Barra community and the Health Education League for their collaborative work and Silvia Morreale for assistance with the Spanish translation of the Abstract. MF's participation in writing this article was supported by a Science Without Borders Summer Research Project grant."

References

1. Fleury S. Brazil's health-care reform: social movements and civil society. Lancet. 2011;377.
2. Declaration of Alma-Ata. International Conference on Primary Health; 1978; USSR. World Health Organization.
3. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: history, advances, and challenges. Lancet. 2011 May 21;377(9779):1778-97.
4. Coelho VSP. Brazil's Health Councils: The Challenge of Building Participatory Political Institutions. IDS Bulletin 2004;35(2):33-9.
5. Cornwall A, Cordeiro S, Delgado NG. Rights to health and struggles for accountability in a Brazilian municipal healt council. In: Newell P, Wheller J, editors. Righs, Resources and the Politics and Accountability. London: Zed books; 2006.
6. Coelho VSP, Cornwall A, Shankland A. Taking a Seat on Brazil's Health Councils. Citizenship DRC Case Study Series. 2009:2.
7. Jupp D, Ali SI. Measuring Empowerment? Ask Them. Quantifying qualitative outcomes. Stockholm: SIDA; 2010. Report No.: SIDA53691en Contract No.: Document Number|.
8. Aujoulat I, d'Hoore W, Deccache A. Patient empowerment in theory and practice: polysemy or cacophony? Patient Educ Couns. 2007 Apr;66(1):13-20.
9. Neto MMdC. A Implantação da Unidade de Saúde da Família. In: Básica DdA, editor. Brasília: Ministério da Saúde; 2000. p. 44.
10. Rosa WdAG, Labate RC. Programa Saúde da Família: a construção de um novo modelo de assistência. Rev Latino-am Enfermagem. 2005;13(6):1027-34.
11. Diretrizes nacionais para o processo de educação permanente no controle social
do SUS / Ministério da Saúde. In: Saúde CNd, editor. Brasília: Editora do Ministério da Saúde; 2006. p. 40.
12. FAMÍLIA FESD. Guia para a Implatação e desenvolvimetno de Conselhos Locais de Saúde. Salvador: Núcleo de Gestão Participativa; 2010. p. 13.
13. Silva CMdC, Meneghim MdC, Pereira AC, Mialhe FL. Educação em saúde: uma reflexão histórica de suas práticas. Ciênc saúde coletiva. 2010;15(5):2539-50.
14. Vasconcelos EM. Educação Popular: de uma Prática Alternativa a uma Estratégia de Gestão Participativa das Políticas de Saúde PHYSIS: Rev Saúde Coletiva. 2004;14(1):67-83.
15. Almeida-Filho N. Higher education and health care in Brazil. Lancet. 2011;377:1898-900.
16. Vasconcelos EM. Redefinindo as práticas de Saúde a partir de experiências de Educação Popular nos serviços de saúde. Interface- Comunic, Saúde, Educ. 2001;5(8):121-6.
17. Brandão CR. Lutar com a palavra: escritos sobre o trabalho do educador. Rio de Janeiro; 1982.
18. Floss M, Miranda Júnior AD. A colcha de Retalhos: Vivências da Liga de Educação em Saúde. Rio Grande: Editora da FURG; 2014.
19. Floss M, Miranda Júnior AD, Teixeira TP. Liga de Educação em Saúde: reflexões a partir das vivências dos estudantes de medicina da universidade federal de Rio Grande. APS. 2014;17(1):116-9.
20. Miranda Júnior AD, Floss M. Introdução - Lado B. A Colcha de Retalhos: Vivências da Liga de Educação em Saúde. Rio Grande: Editora da FURG; 2014. p. 29-48.
21. Floss M, Tavares RC, Côrrea CR, Miranda Júnior AD. League of Health Education: the Extension and Popular Education experience in medical education. Wonca Europe 2014; 2014; Portugal. 2014.
22. Freire P. Pedagogia da autonomia: saberes necessários à prática educativa. 15 ed. São Paulo: Paz e Terra; 2000.
23. Freire P. Education for critical consciousness. London: Continuum; 1974.
24. SPRG SdPdRG. The City of Rio Grande. Rio Grande: Superintendência do Porto de Rio Grande; [cited 2014 20th October]; Available from: http://www.portoriogrande.com.br/site/sobre_porto_municipio_rg.php?idIdioma=2.
25. Barcellos J. A Vila da Barra e questões ambientais. Jornal Agora. 2010.
26. GAB GdAdB. Nossa História. Rio Grande; 2013 [updated 2013; cited 2014 03 november 2014]; Available from.

27. Freire P. Pedagogy of freedom : ethics, democracy, and civic courage. Lanham: Rowman & Littlefield Publishers 1998.
28. Reis S. Modelando o Caminho da vida. A Colcha de Retalhos: Vivências da Liga de Educação em Saúde. Rio Grande: Gráfica da FURG; 2014.
29. Prado EVd. O Diálogo como estratégia de gestão no SUS. II Mostra Nacional de Experiências em Gestão Estratégica e Participativa no SUS; Brasília. Ministério da Saúde. p. 6.
30. Vasconcelos EM. Educação Popular nos serviços de saúde. São Paulo: Hucitec; 1997.
31. Feste C, Anderson RM. Empowerment: from philosophy to practice. Patient Education and Counseling, . 1995;26:139-44.
32. Laverack G. Improving health outcomes through community empowerment: a review of the literature. J Health Popul Nutr. 2006 Mar;24(1):113-20.
33. Baxi U. Human Rights in a Posthuman world. 3 ed. New Delhi: Oxford University Press; 2010.
34. Hunt P, editor. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health UN General Assembly; 2006. UN.
35. Saha S. Amartya Sen's Concept of Human Rights: Agency's Vital Rol. Forum on Public Policy; 2011. The Forum on Public Policy; 2011.
36. Freire P. Pacientes impacientes: Paulo Freire. Caderno de Educação Popular e Saúde. Brasília-DF: Ministério da Saúde; 2007. p. 32-44.