

# Enhancing Critical Reflection of Brazilian Community Health Agents' Awareness of Social Determinants of Health

SAGE Open  
October-December 2014: 1–14  
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DOI: 10.1177/2158244014556632  
sagepub.com  


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## Abstract

This project aims to assess how Brazilian community health agents' critical awareness of the social determinants of health was enhanced and led to a greater understanding of the major structural changes necessary to sustain health promotion initiatives. Educational workshops inspired by Paulo Freire's ideas on critical pedagogy were delivered to 82 community health agents in three Brazilian cities. The workshops utilized evocative objects to link and develop participants' conceptual and experiential knowledge. The participants exchanged connections and experiences and created hypothetical action plans to be implemented in collaboration with community members. The discussions were audio recorded, transcribed verbatim, and submitted to content analysis. The connections provoked by evocative objects were related to required assets for the development of a healthy community. As social advocates, they are already committed to a social movement for health equity to catalyze a more equitable distribution of social goods, promote social inclusion, and liberate communities.

## Keywords

community health agents, social determinants of health, health promotion, professional training, critical reflection

## Introduction

Systemic actions to promote global health and health equity may be jeopardized by the restriction of knowledge dissemination to frontline professionals working in communities to better connect socially disadvantaged populations with health care services. For the past five decades, the Brazilian government has focused on economic growth and development, transforming a mostly agriculturally based economy to an industrialized one. Despite that effort, social disparities and health inequities are still apparent (Comissão Nacional sobre Determinantes Sociais da Saúde, 2008). Brazil's community health agents (CHAs), as they are officially named, have begun to address some of the health disparities by taking a more central role in linking communities to the health care system, influencing community development, health education, and advocating for social justice and health equity (Côté, Renaud, Rhéaume, & Zanchetta, 2010; Pinto, da Silva, & Soriano, 2012; Zanchetta, Kolawole-Salami, Perrault, & Leite, 2012).

Before proceeding, let us clarify two of our terms. Our definition of social determinants of health (SDH) is in line with that of the World Health Organization (WHO; n.d.).

Nonmedical determinants of health are largely specific to the places where the individuals are born, live, work, and age. These determinants, shaped by the distribution of resources, money, and power, are related to health inequities. Also, the term "community health agent" is not interchangeable with that of community health workers as found in the international literature. Brazilian CHAs are individuals who have received professional training and are officially recognized

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by legislation; so they are professionals in a unique administrative and legal position in Brazil. CHAs are paid professionals working as active members of a family health team (FHT; affiliated with the National Family Health Strategy) within the Brazilian National Unified Health System. In Brazil, FHT refers to a primary health care team composed at minimum of physicians, university educated nurses, auxiliary nurses, nurse technicians, CHAs, administrative staff, health vigilance agents, and technical manager; if enlarged, this team also includes dentists, oral health technicians, and other health professionals. The FHT undertakes fundamental action for health promotion, prevention, recovery, and rehabilitation. The FHT also monitors health conditions in a given geographic region (Secretary of Health and Civil Defense of Rio de Janeiro, n.d.).

To ensure CHAs' ability to offer a range of services to address health inequities, it is important that continuing education be provided through participatory learning that allows for the articulation and validation of CHAs' experiential knowledge (dos Santos & Fracoli, 2010). This article reports the findings of an appraisal of the progressive learning experiences that took place during, and as a result of, an in-service education workshop entitled "Social determinants of health: Knowledge for action." This workshop utilized participatory learning to enhance CHAs' critical awareness of SDH to help them to identify plans of action to strengthen the health of the community where they live and work. The workshop aimed to enhance CHAs' critical reflection on their health promotion work while introducing conceptual knowledge and Brazilian empirical evidence about SDH. These workshops were delivered as part of a large international knowledge dissemination project on SDH undertaken by Brazilian and Canadian university faculty members and targeted to educators, students, professionals, and community stakeholders.

## Background

CHAs are key personnel who work under the direct technical supervision of university educated nurses and receive in-service education and mentoring from nurses (Zanchetta, Leite, Perreault, & Lefebvre, 2005). CHAs provide health services within their own communities to address diverse health inequities and link citizens to the national, unified health system (Pinto et al., 2012; Zanchetta et al., 2012). The work setting includes a community health center where an array of primary and secondary health care services is free and accessible for the local population as part of national health programs. In addition to working with multiprofessional team members at the community health center, CHAs provide home visits, participate in public health campaigns, deliver health education, home care, rehabilitative care, and clinical follow-up care, and accompany medical consultants to home visits. CHAs work within FHTs to provide primary health care to approximately 99.4 million individuals across

Brazil, primarily within impoverished communities (Ministério da Saúde, n.d.).

To address health disparities faced by their communities, CHAs need to understand and recognize the inherent causes of community inequities (dos Santos & Fracoli, 2010). However, gaps in awareness and understanding of SDH as the source of health inequities may limit CHAs' ability to promote health through social justice initiatives (Zanchetta, Kolawole-Salami, Perrault, & Leite, 2012; Zanchetta et al., 2009). Current education offered to CHAs (Ministério da Saúde & Ministério da Educação, 2004) does not specifically address theoretical knowledge on SDH or focus on developing critical awareness of macro level social influences on health or the possibilities of community collaboration for health improvement (Ávila, 2011; de Barros, Barbieri, Ivo, & da Silva, 2010).

## Guiding Questions

The following questions guided the development of our in-service educational workshop: (a) How could the use of evocative objects enhance the critical awareness of CHAs regarding the identification and application of SDH knowledge in their practice? (b) Through the use of evocative objects and consideration of their relationship to SDH, what hypothetical plans for action could be created by CHAs to improve the health of people living in socially deprived communities?

## Conceptual Framework

Freire's philosophy of critical education for liberation and social change (Freire, 1973) espouses social justice, equality, freedom, and democracy through the development of learners' critical consciousness (Gibson, 1999). These ideas inspired the workshops' learning objectives, content delivery, individual and group learning activities, and basis for workshops' evaluation. For Freire, education must stimulate a desire for action that addresses inequity and oppression. A dialectic approach between teachers and learners taps the latter's experiential knowledge (Freire, 1973). To do so, teaching incorporates evocative objects (e.g., photographs, drawings, or objects). In Freire's dialectical dialogue between educators and learners, evocative objects are those that can recall familiar reality (Freire, 1973). They are used to aid in the recognition of existing ideas and experiences in their lived world. These objects provoke memories, ideas, and connections that guide self-reflection on learners' reality and practice and are used to promote transformation. Those objects help learners recall their lived experience (Freire, 2001) and encourage them to reflect on this and consider how to act against the injustices that individuals and communities encounter.

Learners are also asked to reflect on the underlying reasons for social problems in ongoing critical dialogue with

teachers. This process of consciousness raising, in which learners critically insert themselves into the social and political contexts, transforms apathy into denunciation of injustice (Freire, 2001). The use of this framework is congruent with long-standing official educational initiatives widely implemented with CHAs (Coriolano, Lima, Queiroga, Ruiz-Moreno, & de Lima, 2012).

## Ethical Considerations

The in-service-educational workshops were planned and implemented in collaboration with FHT managers and were not part of a formal research project; hence ethics approval was not necessary, nor sought. However, following the first author's Canadian institutional ethical guidelines, signed consent forms were obtained from workshop participants granting the right to use recorded material for educational purposes. All CHAs signed consent forms giving permission to the first author, a university professor, to use the workshop photos and audio recorded conversations for educational purposes, evaluation, and publication.

## Method

### Settings

Three in-service-educational workshops, of 4-hr duration each, were held in May 2009 in the cities of Rio de Janeiro (state of Rio de Janeiro), Jequié (state of Bahia), and Fortaleza (state of Ceará).

### Participants

CHAs were recruited through their immediate supervisors from community health centers in these cities. The workshops were conducted at CHAs' workplaces and a university auditorium during working hours to make it convenient to attend. A total of 82 CHAs, 74 women and 8 men, participated in the three workshops.

### Workshop Conception and Planning

The workshops required minimal infrastructure and were low cost (the average price per evocative object was Can\$1.15). Following Freire's critical pedagogy that recommends the use of familiar, common objects, the facilitator purchased 90 objects with the potential to elicit thoughts about SDH. The facilitator's (MZ) selection of objects was based on her knowledge of SDH, the practice of CHAs, and the overall social contexts of the cities in which the workshops were offered. The sum of these factors ensured the appropriateness of all objects as well as their inner potentiality to evoke CHAs' culturally bonded lived experiences. To prevent direct suggestion of the meanings by the objects, the facilitator selected mundane objects that could suggest a link

to a SDH; for instance, a calculator, money purse, cap, grass, tuna can, instant soup, and laundry powder. Some of the other objects used are listed in the tables that follow. In fact, the intention was to allow CHAs to freely relate the workshop's content with their experiential knowledge and associate it with a SDH. As a result, CHAs would attribute a conceptual meaning to their knowledge and become aware of it. Such use of evocative objects is consistent with Freire's pedagogy and helps to uncover awareness of SDH by linking evocative objects to CHA practice.

### Workshop Development

The workshops were facilitated in Portuguese by the first author, who is a Brazilian-born and Brazilian-educated nurse, and attended by five other members of the Canadian multidisciplinary team, as well as six Brazilian faculty members and managers from local community health centers. The facilitator was knowledgeable about Freire's pedagogy and Brazilian sociocultural reality, which ensured that her comments and insights evoked in the workshops were appropriate to CHAs' working environments.

The first phase of the workshop lasted 45 min and consisted of discussion and reflection on class dynamics within the CHAs' communities, with emphasis on the concepts of happiness–health, health equity–inequity, and opportunities for community social development. The facilitator introduced the WHO's definitions of SDH (WHO–Commission on Social Determinants of Health [CSDH], 2008), knowledge network, and action framework. The facilitator also displayed seven photos of a Rio de Janeiro shantytown (taken by CHAs), which portray the impoverished living conditions, to ground the analysis of community health promotion within the actual environmental, structural, cultural, and economic contexts. Information was presented from the Oswaldo Cruz Foundation website where the work of Brazil's National Commission on Social Determinants of Health (NCS DH) is available for consultation. Afterward, the facilitator introduced excerpts from the NCS DH Report (Comissão Nacional sobre Determinantes Sociais da Saúde, 2008).

Data were presented on socioeconomic inequities in Brazil, primarily on issues of access to health information, population health literacy, maternal child mortality, and health in North and Northwest poor regions, First Nations health, and vulnerable groups in urban centers. The presentation ended with a summary of the NCS DH report's findings on social inequity as the basis for Brazil's most serious public health problems, a final remark about the concept of social vulnerability, and rhetorical questions about what should be done to improve the health of individuals in their communities. This was the bridging issue to guide the CHAs toward the practical phase of the workshop, using the evocative objects (see Table 1) to prompt learning and discussion.

The workshops' sequential steps are presented in Table 2. The complete workshop—whole class presentations and

**Table 1.** Free Association Flow Linking Evocative Objects to CHAs' Experiential Knowledge of SDH.

Evocative object and SDH	Flow of ideas based on CHAs' experiential knowledge
Key and housing	<ul style="list-style-type: none"> <li>• Key for hope → allows opening of doors → “doors” are closed to the community → breakdown of barriers to opportunities</li> </ul>
Cell phone and income	<ul style="list-style-type: none"> <li>• Lack of a national housing policy → people need appropriate home in a wooded area → income too low to afford rent → area invasion → temporary housing → no basic sanitation → places not reached by government policies for health and security</li> <li>• Poor social class → social status of an unemployed teenager → families financially deprived → teenager wants a cell phone → family violence</li> <li>• Means of communication linking all social classes → social networking → daily communication with Primary Health Team workplace → social inclusion/exclusion → interaction among people → giving and receiving</li> </ul>
Wallet and income	<ul style="list-style-type: none"> <li>• Money → job → better life conditions → house → food on the table</li> <li>• Money → conditions for health → good housing → healthy nutrition → conditions for supporting medical treatment</li> </ul>
Savings box and income	<ul style="list-style-type: none"> <li>• Inequity in income distribution</li> <li>• Savings → precaution → emergency need for money</li> </ul>
Lawn and environment	<ul style="list-style-type: none"> <li>• Public Square → lack of local public space in community → lack of places for children to play → no place for seniors' leisure → walking → need for more trees in community → reduce respiratory infections</li> <li>• Concerns about forest → concerns about domestic garbage → environmental destruction → burning of forest and bush</li> </ul>
Floating rose and environment	<ul style="list-style-type: none"> <li>• Childhood memories → pollution levels → destruction of lake fish and water contamination → people drinking contaminated water → health hazards → decontamination work needed for flora to recover</li> <li>• Reminder of the <i>Victoria regia</i><sup>a</sup> → important to the purification of rivers, lakes, and aqueducts → contribution to world health</li> </ul>
Pair of glasses and access to health care	<ul style="list-style-type: none"> <li>• Difficulty booking a consultation with an ophthalmologist → several cases of visual problems → social inequality → no money to purchase required glasses</li> <li>• Protection against sunlight → useful to give wide protection to the community → amplified vision → clear vision of problems' origins → opportunities to perform big deeds → differentiated views</li> </ul>
Wooden spoon and food security	<ul style="list-style-type: none"> <li>• Food → a man who cooks for his kids → woman as a home warrior → woman who fights for food → family and home</li> <li>• A tool to prepare meals, but not the raw ingredients → job precariousness → family instability → domestic violence</li> </ul>
Plate and food security	<ul style="list-style-type: none"> <li>• Cook → profession → spoon is a professional tool</li> <li>• Empty plate → hungry → malnutrition → unemployment → false public policies → social exclusion → food → begging for food → lack of dignity</li> <li>• Full plate → access to education → favorable public policies → food on the table → employment → abundance for few people</li> </ul>
Jump rope and health literacy	<ul style="list-style-type: none"> <li>• Physical activity → large obese population → poor nutrition → lack of vegetables and fruits → possibility of forming a walking group</li> <li>• Childhood → destruction by violence → obesity → exercise combating obesity</li> <li>• A worker who lost his job → despair → used rope to hang himself</li> </ul>
Hawaiian lei and culture	<ul style="list-style-type: none"> <li>• Carnival → exteriorization of lack of opportunities in the community → type of happiness → happiness embraces everything, even health → joy</li> </ul>
Flute and culture	<ul style="list-style-type: none"> <li>• Lack of cultural activities for teenagers and children → need to establish links outside the community → go beyond local culture → importance of theater for children</li> </ul>
Set of furniture in a doll house and healthy childhood development	<ul style="list-style-type: none"> <li>• Minimum comfort that all have the right to → toys → children's right to play → loss of childhood due to necessity to work to increase family income</li> </ul>
Baby bottle with candies and healthy childhood development	<ul style="list-style-type: none"> <li>• Breast milk → replaced by industrialized milk → health problems → candy jeopardizes health</li> </ul>
Pencil case and education	<ul style="list-style-type: none"> <li>• Education → hard to access → equal education for all → good quality education → education to inform adults about rights and duties</li> <li>• Unrecognized personal potential → lack of information about rights → all must understand that they have a right to voice their claims and influence legislative change → study about health</li> </ul>
Motorcycle and transportation	<ul style="list-style-type: none"> <li>• Alternative means of commuting → teenagers and children involved in drug dealing</li> <li>• Easy access to shantytown pathways → access to shopping → minimize travel distances → promote integration of those hard-to-access places</li> </ul>
Lint brush and social network	<ul style="list-style-type: none"> <li>• Social network of housemaids → domestic work → hard life → symbol of Brazilian woman → hard worker → humble → poor family → difficulty in educating her children → hard to achieve improvements in life</li> </ul>

Note. CHA = community health agent; SDH = social determinants of health.

<sup>a</sup>*Victoria regia* is a flowering floating plant found in the shallow waters of some Brazilian rivers, lakes, and bayous.

**Table 2.** The Workshop Steps.

Steps
The facilitator asked CHAs three preassessment questions: (a) How is happiness part of health? (b) What do you consider unfair and unnecessary? (c) What kind of opportunities and possibilities for healthy living do not exist in your community?
The facilitator delivered a 45-min presentation on the conceptual background of SDH, SDH indicators in Brazil, global health issues, and social inequities and praxis, with direct reference to CHAs' personal knowledge about factors that influence population health.
The facilitator asked CHAs to form small groups of four to six.
The facilitator distributed evocative objects and asked participants to individually reflect on the object for 2 min.
The facilitator asked participants to ponder the relationship between the evocative object and the theoretical knowledge presented, their personal experience, and the reality of their community or their professional practice.
Each CHA spent 3 min disclosing their thoughts about the evocative object and identifying SDH associated with it.
Each group chose one SDH and developed a short-term plan of action that could be initiated within their communities.
The groups presented their action plans.
The facilitator distributed a postworkshop summative evaluation form.

Note. CHA = community health agent; SDH = social determinants of health.

discussions and sub-group discussions—were digitally audio recorded. Participants' immediate, postworkshop summative evaluation was done.

To promote further education on SDH, copies of Raphael's (Raphael, 2009) book on Canadian perspectives of SDH were donated to local Brazilian faculty, and two copies of Brazil's NCSDH Report on SDH were distributed per workshop site to selected participants, with a recommendation that the reports be shared with CHAs who were unable to attend the workshop.

### Data Analysis

Three undergraduate students in Brazil transcribed the audio recordings of the complete workshop activities. M.Z. worked with two Brazilian students in Toronto to code and analyze the transcribed texts, manually applying Bardin's method of content analysis (Bardin, 2007). They looked for evidence of CHAs' recognition of SDH as a main concept, as well as expanded knowledge and awareness of SDH in CHAs' daily practice; they coded descriptions and representations of SDH along with proximal descriptive words, created categories of meaning, analyzed polarized themes, and identified associations among the conceptual categories (Bardin, 2007).

### Results

Evidence of CHAs' enhanced awareness about SDH during the workshops is presented as CHAs' reactions to pedagogical moments, along with the process of how CHAs built their understanding of SDH in their practice. The workshop was not part of a formal research project; therefore, no socio-demographic data were collected on participants. Quotations identify only the CHA's city of origin. Because this was not an intervention study, but rather a workshop to inspire action based on knowledge on the SDH, no premeasurements and postmeasurements were taken of the

participants' knowledge of SDH. Evidence of what was learned emerged from the shared self-reflections and group discussions, which is compatible with the theory of critical awareness in learning as proposed in Freire's pedagogical philosophy (Freire, 1973).

### CHAs' Awareness of SDH From Lived Experience

The CHAs' responses to workshop questions revealed beliefs that both health and life should be joyful experiences and that people need shelter, financial security, and clean living conditions as the basis for this. People should have a good quality of life in a supportive context, adopt positive attitudes, and not feel like a burden on others. CHAs demonstrated awareness of SDH in their attempts to enhance the health and well-being of community residents. This included the social environment, as evidenced by the following quotation:

After hospitalization, the once drug addicted person comes back home, regenerated and treated, but to the same place he lived before. (CHA, Rio de Janeiro)

To clarify the concept of health, the facilitator-led presentation displayed four images: an older woman lying in a hospital bed, a child playing with toys, a man rubbing his face, and a group of teenagers sitting on the steps of a church. The facilitator asked CHAs for their opinions about the health of the people in each of the images. One CHA responded,

I think that health is essential to happiness and happiness to health. (CHA, Rio de Janeiro)

CHAs were also asked about their knowledge regarding the following paired concepts: equality and inequality, equity and inequity. CHAs' experiences in Rio de Janeiro's shantytowns provoked vehement statements such as,

**Table 3.** Dimensions of Healthy Community Development That Emerged From Analogies Induced by Evocative Objects.

Dimensions of a healthy community development	Analogies induced by evocative objects
Alliances	Communication and sociability; breaking structural barriers; mutual help; community links; women's social networks; self-esteem boosting
Structure	Rights to comfort; access to all of societal goods; access to health care; green space; more equal income distribution; alternative transportation
Values	Enlarging vision; promoting happiness and health; challenging social exclusion

The involvement that kids have with drugs is unfair and unnecessary. The lack of vision in public policies is unfair, as it considers the shantytown inhabitants as second-class citizens.

When initiating the small group exercise, a collective awkwardness was observed among the CHAs after they were instructed to connect the assigned object to their daily experiences. The CHAs remained silent for 2 minutes, as requested, and individually reflected on the object and its relation to their practice and experiences; then, CHAs eagerly participated in the 3 minutes small group discussions about potential connections provoked by each object. When each of the small groups presented their connections to the whole class, a rapid comprehension of the concept of SDH and the evocation of a creative and complex chain of ideas were observed as a flow of comments on negative/undermining consequences and outcomes. Gradually, CHAs acknowledged their peers' chain of ideas and made comments that corroborated the pertinence of associations and connections within a macro level context of social inequities witnessed in their communities.

Initial contact with the distributed evocative objects provoked laughter and surprise because they were simple, playful, funny, colorful, and easy to manipulate. One CHA explained her immediate reaction to the instructions for the object she received:

... not everyone will agree because when we look at the object and listen to someone else's ideas, we may interpret it in a different way. (CHA, Fortaleza)

The connections that CHAs developed were analyzed by M.Z. and A.O. and classified according to three dimensions required for the development of a healthy community: *alliances*, *structure*, and *values*. These connections helped CHAs eventually connect lived experiences with the concept of SDH (see Table 3). *Alliances*, in the community context, refer to connecting individuals and creating a strong community bond. It was represented in CHAs' discourse by ideas including the communication and social cohesion necessary to break down barriers to mutual help. CHAs saw the *structure* necessary for community development as rooted in several rights denied to individuals in deprived communities: the right to comfort, access to all of society's goods, access to health care, the right to green space, the right to equality of

income, and access to transportation (which in shantytowns usually means motorcycles, especially those shantytowns built on steep hills and those with few paved streets). *Values* were the final dimension of community development that was emphasized. CHAs felt that new values are necessary to broaden residents' vision of life in their communities, to promote happiness and health, and to resist social exclusion.

The CHAs were also able to relate the theoretical knowledge about SDH presented by the facilitator to their experiential knowledge, through their reflections on the evocative objects (see Table 4). Essentially, CHAs already possessed some understanding of SDH. One of the most often identified SDH was food insecurity resulting from social exclusion, a more complex issue than that caused solely by restricted access to job markets. For example, the discussion about food insecurity was related to the notion of social exclusion and metaphorically expressed by CHAs as having "all doors closed to the community." CHAs emphasized that low health literacy, illiteracy, and limited access to education resulted in less understanding of nutritional information and the correct preparation of food. Unsafe conditions due to the danger of being shot or even prohibited by drug lords to leave their home prevents individuals from freely walking in their communities, resulting in frequent missed work and school days and eventually dismissal. Moreover, other CHAs emphasized that food insecurity was a major social issue for seniors or adult individuals who did not possess the documents required to enroll in food distribution programs. These were a few examples of undervaluing and overlooking human potential that challenge the simple idea of access to the job market to earn income; access to food assumes having the freedom to reach shops, to be a documented citizen, to be literate and educated. The CHAs' comments and lines of thought revealed how they connected their experiential knowledge with the theoretical knowledge presented in the workshop, and their new understanding of SDH motivated the CHAs to change how they understood community inequities.

### Creation of Hypothetical Action Plans

A greater understanding of SDH was demonstrated when each small group developed and presented their hypothetical, but feasible, short-term action plan, involving collaboration

**Table 4.** Links Between Evocative Objects and Social Determinants of Health, With Relevant Quotes.

Evocative object	SDH	Quote
Grass	Environment	I would say to my community to preserve nature and avoid throwing garbage away in the bushes. (CHA, Fortaleza)
Floating rose		This is a rose floating in the water . . . I saw many roses like this one when I was a child on my father's farm. When it is in the rivers, we think about how it protects something. The pollution today destroys the rose and contaminates water we consume, directly affecting our health. (CHA, Jequié)
Pair of glasses	Access to health care	It reminds me of the difficulties that people in my community have to book an appointment for eye exams. They have so many visual problems. (CHA, Jequié)
Wooden spoon	Food security	[A] spoon is a tool. Instead of giving people precooked food, I would give them the tools necessary to prepare their own. It is a social determinant to prevent what? There is hunger, a spoon . . . I see the spoon as a means to avoid hunger. (CHA, Fortaleza)
Plate		It represents food on the table. It means employment, that without a job no one can put food on the table; it represents hunger, as many do not have even beans to eat. (CHA, Jequié)
Hawaiian lei	Social environment	This is a flower necklace . . . and flowers generally remind us of parties and happiness despite the difficulties. Despite the community's challenges and difficulties . . . the underserved people . . . there is a moment of happiness and joy. (CHA, Fortaleza)
	Political environment	This Hawaiian necklace reminds me of Carnival that supposes that all Brazilian can be liberated from all the lack of opportunities as we see in our deprived communities. It is also a kind of happiness and happiness embodies everything. (CHA, Rio de Janeiro)
Flute		I relate it to culture. Thinking about the communities that are deprived of resources for cultural activities for children. I also considered including flute lessons in my project because in my childhood we had those classes and we were so happy. Thus, our children would relate to types of culture other than their own. (CHA, Rio de Janeiro)
Pencil case	Education	It provokes my ideas about education, which is very difficult in our country. I believe that education must be equal for all and of good quality. This could then enable us to educate adults with more general knowledge, who could then become more conscious of their rights and duties. (CHA, Fortaleza)
Set of doll house furniture	Childhood development and Access to health services	It reminds me of a child's toy; also leisure, that everyone has the right to a healthy life. (CHA, Fortaleza)
Baby bottle with candy inside		I would be very happy in knowing that parents would be able to provide good dental care to their children. This would avoid diseases, people would be able to chew better, and better absorb the food they eat. Dental care is expensive, few can afford it, and the treatment provided in the community health center is of poor quality. (CHA, Rio de Janeiro)
Motorcycle	Transportation	I immediately thought about my community [because] it has so many motorcycles there. Unfortunately, when we see a youth driving a motorcycle, we know that he belongs to the drug cartel. (CHA, Rio de Janeiro)
Wallet	Income	Wallet represents money, job, conditions of having a better life with a house, and food on the table . . . everything that comes with money and a job. (CHA, Jequié)
Savings box		My savings box made me think about a determinant factor of unequal income distribution, mainly here in Brazil. (CHA, Rio de Janeiro)
Lint brush	Social network	It represents social networks like the ones created by housewives who even when in the formal workforce still have to work at home. They face a lot of struggles. The symbol of a Brazilian woman is one who is a hard worker, humble, of poor origin, may work as a laundry washer and, with many difficulties, raises and educates her kids, struggling to achieve improvement in their life conditions. (CHA, Jequié)

Note. SDH = social determinants of health; CHA = community health agent.

between themselves and their communities. After working together for about 1 hr, each group selected one SDH and created a hypothetical 6-month action plan to address it. The plans of action included a hypothetical presentation to the community for a future joint project. Initially, CHAs revealed their difficulties in conceiving such collaborative plans. Each plan was mapped out on large sheets of paper and displayed on the wall for presentation to the whole class. No specific guideline was provided to CHAs in regard to the content of the plan other than to operationalize the SDH that they had selected. CHAs freely created the plan's structure, including no less than three of the following components: a community need, objectives, target population, target issue, and key actions. During the presentation of plans, CHAs also learned from their peers. We observed that while groups were presenting, CHAs in other groups discussed and compared content and noted components not incorporated in their own plan. Immediately after each presentation, there was a short period for questions; most of these were about implementation strategies.

Most of the CHAs promptly offered solutions for finding resources to implement the plans, instead of considering how to develop community members' capacity to find solutions by themselves. CHAs acknowledged that this approach of assisting clients rather than capacity building most likely reflects their daily practice and should be changed. By explaining their plan's rationale to their peers, a lively exchange of ideas and suggestions ensued, and the CHAs were able to identify the need for and the strategies required to create collaborative partnerships with their communities, to motivate residents and mobilize their resources, talents, and assets.

The 14 hypothetical action plans were analyzed by the first author and grouped into 5 themes: (a) governance in the health sector; (b) promotion of social cohesion—family interaction, social networking, older adults' well-being, and environmental health; (c) prevention of community violence; (d) development of community centers, community gardens, art and craft workshops; and (e) community forums regarding SDH and workers' cooperatives. These plans also included educational activities to expand mutual respect, civility, and collective wellness. In terms of health promotion strategies (Cohen, 2008), the plans were primarily interventions to create supportive environments, develop personal skills, and enhance community action.

### **Workshop Evaluation**

Questionnaires provided to the CHAs at the end of each workshop were completed by 72% ( $N = 59$ ) of the participants. The questions were as follows: (a) How did this workshop help you to learn about SDH? (b) How did this workshop help you to expand your ideas about the issues linked to social inequities in health? (c) What ideas do you have now about your work with the community? (d) How could this workshop have been more useful for you as a CHA?

The results regarding SDH showed that CHAs learned about (a) global, social inequities in health; (b) feasible collective action through the creation of partnerships; and (c) the need to implement new ideas to change practice and to expand their views of professional action.

CHAs stated that strategies to tackle social inequities by improving life conditions in socially deprived communities are necessary and that they would seek community commitment to achieve common objectives. The key idea was that identification of community issues alone is ineffective; rather, it is crucial to formulate practical ideas to address community issues—be it independently or by increasing social networks with community members, government organizations, or professionals in other areas of activities. This increased commitment to reversing existing inequities in the community may result in a new method of discussing health issues, support to increase the community's responsibilities and rights, or providing essential and adequate information to the community.

The CHAs also revealed that the workshop generated new ideas about their work in regard to consolidating new skills as well as expanding their professional role as a consequence of those skills. These new skills included learning about and understanding government power, improving information dissemination for the mobilization of their community, improving their ability to transmit health information, improving their community collaboration skills, focusing on the causes of issues, and discovering community talents, strengths, and potentials. The CHAs suggested that foreseeable knowledge application would require them to consolidate new skills and adopt some change in their professional roles. The desired improvements to the professional role of the CHA could lead to professional development in their practice. It was proposed that ideas related to personal values be consolidated, perceptions of acting as an agent of change or community leader be enhanced, valorization of their community work be renewed, barriers to their work be conquered, and responsibility regarding social actions be increased.

The CHAs also acknowledged possible innovations for practice because they were able to foresee how they could apply their newly acquired knowledge regarding SDH (as incorporated in their hypothetical plans of action) to develop concrete innovations for their practice. These included establishing new partnerships that would improve their performance in the community. Better performance was identified as creating more job opportunities and promoting more social integration and social mobilization in their communities. CHAs stated that they must not only focus on improving issues of health in their communities but also improve social and educational environments. They recognized the importance of educating community members to disseminate information aimed at promoting social responsibility and new life perspectives.

Finally, the CHAs suggested several changes for future workshops: They recommend (a) incorporating content

about the need to strengthen the professional and individual voice of CHAs, the outcomes when managers and supervisors do increase support for CHAs' work, and strategies to develop projects in partnership with the community, to increase community support, to assist in implementation, to follow-up on community action, and to assist CHAs with the development of solutions for community issues; (b) offering the workshop to all FHT members; (c) increasing the number and frequency of the workshops; (d) having continuity of the workshops; (e) increasing the workshops' duration; and (f) extending the benefit of the workshops throughout Brazil and to all CHAs.

Although we did not intend to evaluate long-term outcomes of the workshops, we later learned that five of the participants implemented several initiatives that demonstrated the incorporation of SDH in their practice months after the workshops. For example, two CHAs in the city of Patacas-Aquiraz (state of Ceará) implemented community initiatives to address child obesity (through games, dance, exercise, nutritional education, and a food fair) in partnership with elementary schools and the local community health center; 200 children took part. Some CHAs started a seniors' discussion group and replicated the workshop for members of their FHT using the same PowerPoint presentation (L. Matos, personal communication, November 20, 2009). In the city of Rio de Janeiro, two groups of CHAs implemented their plans of action in partnership with Environment Agents. In one educational session, CHAs addressed issues of shantytown reforestation by distributing free seedlings for residents to plant in their preferred areas. As the result of another initiative addressing the issue of waste collection by municipal public services, one community resident installed a barbed wire fence to control waste disposal in certain areas and started to educate others to keep their community clean and healthy (Z. da Cunha, personal communication, August 2, 2010).

### *Dialogue Among CHAs, Community Residents, and the Canadian Team*

The dialectical encounter of experiential knowledge and ideas is for Freire (1973) the core of the teaching-learning process, when teachers and learners have interchangeable positions while creating new critical knowledge. Throughout the workshop, CHAs provoked new insights about the political roots of the SDH; consequently, the facilitator reviewed her understanding of SDH as experienced by socially deprived populations living in shantytowns. The facilitator developed a deeper understanding of the political roots that generated a systemic deprivation of resources and goods, a direct result of authorities' compromised governance and neglect of the rights of citizens living in places reflecting a type of geography of social exclusion, currently acknowledged in Brazil as deprived areas (L. C. Leite, personal communication, May 15, 2009). By overlooking issues of proper

sanitation, drinkable water, clean physical environment, urbanization, public safety, and transportation, among others, all levels of government (municipal, state, and federal) undermine the material and social conditions for health promotion and maintenance. The facilitator realized that because long-standing government neglect reinforces social exclusion in certain communities, the SDH should be reframed to incorporate political literacy and community capacity building for advocacy.

As a consequence, the facilitator concluded that under such circumstances, no major changes could be accomplished by CHAs without promoting wide social support as one of the key SDH to raise community self-esteem necessary for collective action for change. Another aspect of the teaching-learning process was an indirect, modified dialectical dialogue between members of the Canadian team as learners and the local population and CHAs as teachers. It was necessary for the Canadian team to learn about the contextual realities of CHA work in shantytowns. During the fieldwork, daily encounters between CHAs and Canadian team occurred, with both sides eager to learn from each other about SDH in their respective countries. This resulted in a bidirectional flow of knowledge that could be described as a dialogue that unfolded in different ways. First, only the Portuguese-speaking lead facilitator was able to interact directly with workshop participants, while other members of the Canadian team and the Brazilian faculty and managers were observers. Our ongoing debate about SDH as lived in Brazil and in other countries probed the structural issues of SDH in developed and developing countries. Second, the facilitator acted as an intermediary for the indirect dialogue between the workshop's participants and the other members of the Canadian team during a postworkshop debriefing meeting where she reported on the core issues discussed as well as the manifestations of progressive learning about SDH by the CHAs. Third, members of the Canadian team conversed with CHAs and their clients during several home visits while visiting diverse community organizations and individuals (e.g., health authorities, researchers, politicians, media professionals, health care managers, union representatives, and head of philanthropic associations) in each of the cities. An extensive, critical dialogue was possible because Brazilian students and faculty acted as translators and interpreters for all these encounters.

For the most part, this dialogue compared the national situations, including socio-demographic statistics and official health promotion policies. By exchanging information with residents of shantytowns and poor, urban neighborhoods as well as with CHAs, members of the Canadian team developed a new conceptual understanding of SDH within the Brazilian socioeconomic and cultural perspective. After analyzing the results of the qualitative findings and information gathered, we realized that two distinct views of SDH were at play. First, CHAs portrayed SDH as pieces in a "domino-effect" (which was corroborated by local

population and health professionals) wherein the imbalance of just one piece would be enough to demolish a fragile structure to promote health. Even though Brazil has recently implemented several beneficial social programs, they have only gradually minimized the negative impacts of multidimensional deprivation. Second, the Canadian team viewed SDH as being components of a web whose stability would be achieved by a wide array of philanthropic and voluntary community organizations counteracting the deleterious impacts of inequities, not only in Brazil but also in socially deprived communities in Canada. As educators in health and social university programs in Canada, we were able to see how learning about the perspective of CHAs through dialogue might be transferred to further develop the capacity of students in Canada to recognize the links between SDH and health outcomes in deprived communities as well as create actions for social change.

We understood that in a society whose primary health care programs have not incorporated an appreciation of the social dimension of health experiences, it is a challenge to recreate a new vision of health inequities. Brazil's health care system has been a neophyte in relation to the concept of SDH; this has been somehow overlooked and is being slowly recognized. Brazil's social problems underpinning poor population health are being reconceptualized using the language of SDH, and in the past 8 years this has been widely discussed by civil society actors, even by candidates for the presidency. The SDH are progressively being incorporated into official policies, the education of social and health professionals, and in-service education of popular health promoters, among them the CHAs. The resulting learning for the Canadian team was that after almost 40 years of the incorporation of SDH in Canadian primary health care policies, we may fail to realize how in developing countries with a history of abandonment and neglect by governments, the normalized status quo makes it more challenging to use SDH as the basis for a call for action and the concept may resonate less.

## Discussion

At the time of the workshops (spring 2009), the concept of SDH was being introduced into the Brazilian context of health promotion. This was mainly due to work of the NCSDH that advocated for the inclusion of SDH in government policies and programs, an approach addressed by presidential candidates prior to an election. As the NCSDH report was published in 2008, there had been little time for societal debate about SDH and no in-service education for CHAs on the topic. So during the workshops, some CHAs recognized the term SDH while others related it to the social issues their clients faced.

The use of evocative objects in this workshop had similar impacts on learning and awareness about SDH as revealed in other workshops using the same teaching approach with Canadian health and social services professionals (Zanchetta,

Maheu, Salvador-Watts, Fontaine, & Wong, 2014). While authors have reported on the use of Freire's critical pedagogy for decades in teaching initiatives aiming to help professionals reflect on learners' cultural worlds and lived experiences (Wallerstein & Bernstein, 1988), our review of the literature retrieved only one study that explicitly stated the use of evocative objects (i.e., pictures) guided by Freire's pedagogy to educate community health workers about community organization and mobilization (Perez, Findley, Mejia, & Martinez, 2006). While this approach makes our findings unique and adds a further strategy on educating communities and health workers about SDH, the limited reporting about the use of this approach makes it difficult to compare with other studies.

In the workshops, the concept of happiness was introduced by the facilitator, who as a Brazilian who had previously worked with CHAs and their clientele had validated the importance of happiness as a relevant component of the notion of being healthy (Zanchetta et al., 2014) for inhabitants living in shantytowns and poor neighborhoods. It was conceptually justified because happiness as a goal for Brazilians has historical cultural roots since colonization (Ribeiro, 2000). It is noteworthy that Freire's seminal work of the pedagogy of the oppressed (Freire, 1970) has strong sociopolitical and humanistic inspirations that respond to the contextual neglect of basic human rights. As social deprivation results from neglected rights, a well-known reality for CHAs, during the discussions, CHAs expressed ideas about a moral stance to protect the social vulnerabilities of their communities as well as the need of mobilizing communities with the values of social solidarity and citizenry leadership. This was the main notion of values shared by CHAs. By doing this, CHAs may reshape their practices and relations with different professionals and political authorities in the process of claiming the collective moral duty of restoring and repositing humanistic actions at the core of health promotion initiatives.

By connecting theoretical knowledge about SDH with CHAs' experiential knowledge and reflections about their daily practice, the workshops seemed to help CHAs revisit the idea of working in partnership with the community as well as to work toward community capacity building and dealing with issues of power sharing within the FHT as well as in the communities (Zanchetta et al., 2005). The workshops were more than a forum for acknowledging the challenges and barriers to act against social inequities (a "limit-act," as Freire [1970] calls this) because CHAs' awareness of such barriers was already engrained in their motivation to become a CHA (Zanchetta et al., 2005). What the workshops offered to CHAs was tools to boost their citizenry leadership in partnership to change practice and fight for social transformation.

This connection raised by CHAs' critical consciousness of health motivated them to align their practice in their respective communities with health promotion principles

(Côté et al., 2010). Such community-centered practice should support planned community action driven by social change through reinforcing community autonomy, solidarity among residents, and their democratic participation in community projects. As Cronin and Connolly (2007) highlight, incorporating experiential learning and reflective practice into health promotion is critical for analyzing and questioning existing professional, socioeconomic, and political contexts. CHAs' answers to the existing knowledge and bridging questions to new content illustrated that they possessed experiential knowledge that could be conceptually linked to SDH.

Governance in the health sector (including better relations with the FHT to expand their role as agents of social change), promotion of social cohesion, prevention of community violence, and environmental improvements were cited by CHAs as the most crucial aspects of health promotion for Brazil's disadvantaged communities. Acting as knowledge multipliers *with* their communities, rather than *for* communities, CHAs can amplify the community's voice in drawing attention to their unfavorable living situation and associated SDH. This role seems also to be central to community health workers in other countries, who identify the need to recognize and acknowledge community health workers' voices within their communities (Mack, Uken, & Powers, 2006). In the workshops, CHAs became aware of the urgent need to partner with their communities in identifying priority areas for collective empowerment to battle long-standing SDH inequities. CHAs acknowledged the absolute pertinence of identifying and mobilizing community strengths to promote health and change social conditions.

As documented by de Jesus (2010), CHAs require their managers' support and new organizational policies to implement innovative social and health promotion initiatives with their communities. The role of CHAs includes promoting the health-related strengths, challenges, and perspectives of their communities to institutions, organizations, and government bodies that may not understand communities' true health issues (Catalani, Findley, Matos, & Rodriguez, 2009). Ultimately, it is a systemic, multilevel lack of support for addressing health challenges, as defined by communities, that perpetuates the lack of opportunities for improvement. Opportunities for critical, participatory in-service learning may advance the knowledge and competence of those who work with communities, especially CHAs, and their ability to critically reflect upon the consequences of SDH inequities. The workshops helped CHAs to expand their horizons, thus envisioning a more participatory practice. They acknowledged that their community problems are persistent, multidimensional, and not exclusive to economically deprived communities.

CHAs' enthusiastic participation in the workshop discussions revealed their strong motivation to help their communities awaken their own will to push for change. CHAs have an intense desire to redress inequities in deprived communities. They are also aware of their social responsibility as

knowledge multipliers and keen to apply their newly acquired theoretical and empirical knowledge. For these reasons, they wanted to search for new ways to promote a better quality of life for their communities. However, CHAs are aware that their efforts are hampered by poverty, segregation, disrespect for basic human rights, and inequities in accessing shelter and dignified living conditions. These issues continue to pose major threats to global health prospects (Raphael, 2009) and require concerted global efforts to promote health equity. CHAs portrayed health using social-accounting discourse, which emphasizes socioeconomic arrangements (Marmot, 2010). This discourse perpetuates the chasm between wealth and social justice that must be the target of a macro analysis of SDH, the actual cause of health inequities and disparities (Scambler, 2012). The evocative objects encouraged CHAs to associate physical objects with experiences. To do so, they drew on past experiences that were tied to feelings and emotions that helped them to value SDH. Being able to touch, imagine, and visualize these objects helped them to later conceive simple plans of action for their communities.

## Replication and Sustainability Issues

Replications of this workshop should observe the need to use culturally sensitive and appropriate evocative objects and ensure they are gender neutral depending on social, cultural, or religious norms. Feasibility and sustainability of change may be limited because it would require structural changes in sharing power within the professional teams where CHAs or other community health workers work. This limitation should also be taken as a warning when replicating the workshop in other countries. However, the autonomous role of CHAs as insiders in their own communities would counteract some administrative barriers (as indicated by the five CHAs in Rio de Janeiro and Ceará who were successful in implementing significant projects in their communities). While administrative and other barriers may exist, the workshop did provide an initial step to challenging hegemonic notions of power and knowledge within identified communities. Ensuring a concerted approach between our type of workshop and government-sponsored interventions can further help to ensure sustainability of future health promotion interventions.

## Limitations on Findings' Transferability

Several issues may limit the transferability of our findings to other countries, cultures, or other in-service education contexts. People in some cultures may find it challenging to learn through critical pedagogical dialogue and conversation, but rather in a formal way, by listening to educators speak. As the workshops described in this article were meant to build on experiential knowledge, the format may not be applicable to new CHAs or other community workers with little professional experience as health promoters.

## Conclusion

By focusing on community development, CHAs will be able to fulfill the dreams of those visionary health professionals and politicians who, foreseeing radical changes in health promotion, proposed the creation of CHAs within a national program (today called a CHA Strategy) to respond to the absence of social approaches to community health. The conceptual knowledge gained by CHAs through their reflection on evocative objects recalled their lived experiences and sparked the emergence of their hopes and dreams for fairer and more dignified living conditions for their communities. CHAs immediately associated their new expanded knowledge of SDH with a desire to implement change and developed new self-perceptions as empowered professionals who could make change by collaborating with communities in community capacity building.

By transferring knowledge on SDH from the academy to communities, we used workshops as a tool to boost local forces to contribute to the global movement for equity in health. With the workshops, we expanded CHAs' understanding of SDH, which may enhance the quality of their actions and practice. However, CHAs' daily relationships with other members of the FHT, with managers, and with community residents may constrain their future actions. Further studies could explore those intervening factors as well as the success of applying Freire's critical pedagogy in advocating for CHAs' autonomy in their initial and in-service education. The findings may be transferable outside Brazil, because they address two major recommendations of the WHO-CSDH (2008): to inform practitioners about SDH and address the inequitable distribution of power and resources. The findings are transferable to other countries whose community health workers and communities are rallying to confront disparities among social classes, which are, according to Coburn (2010), the causal chain of health inequities.

Although economic development has succeeded in Brazil, Brazilians have been demonstrating in the streets for "rice, beans, health, and education," more recently, for justice in land distribution, and to eliminate systemic corruption. Therefore, the Brazilian government's current interest in SDH is a political decision (Marmot, 2010). As social advocates, CHAs are already committed to this social movement with support from a national government to catalyze a more equitable distribution of social goods and promotion of social inclusion. We are confident that our work provides a new approach to leveraging critical insight on SDH among CHAs to promote justice, equity, and improve health outcomes in deprived communities.

## Acknowledgments

We thank the community health agents who participated in the workshops as well as their supervisors and managers, who made the development of the workshops possible in their Municipal

Community Health Centers. Special thanks to Ivonete Paes (Centro de Saúde Policlínica Nascente in Fortaleza) and Dr. Denise Almeida (Secretaria Municipal de Saúde, Programa da Saúde da Família-Tijuca, in Rio de Janeiro). Special thanks also go to the administration of Sudoeste State of Bahia University (UESB-Jequié) for accommodating the workshop in Jequié. Our special "obrigada" goes to the Brazilian support team composed by the undergraduate students who transcribed the audiofiles as well as to Jaqueline B. Heirendt and Laura D. Zinetti who volunteered in Toronto for assisting in the phase of data compilation.

## Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

This project was supported by 2008 Canadian Institutes of Health Research (Meetings, Planning and Dissemination Grant – International) allowing a team of 4 Canadian faculty and a community organizer to implement this project in Brazil. Faculty of Community Services, Ryerson University, Toronto, Canada provided financial support for internal mobility in Brazil for Alia Maulgue and Jonathan Tel as volunteer students in this project, as well as, a Publication Grant earned by the lead author.

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