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ORIGINAL ARTICLE

POPULAR EDUCATION POLICY: PRACTICES IN THE FAMILY HEALTH STRATEGY*

POLÍTICA DE EDUCAÇÃO POPULAR: PRÁTICAS NA ESTRATÉGIA SAÚDE DA FAMÍLIA

POLÍTICA DE EDUCACIÓN POPULAR: PRÁCTICAS EN LA ESTRATEGIA DE SALUD FAMILIAR

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ABSTRACT

Objective: to understand the practices of health professionals of the Family Health Strategy from the theoretical-methodological principles of the National Policy of Popular Health Education, within the scope of the Unified Health System. ***Method***: this is a qualitative, descriptive study. with eight health professionals, through semi-structured interviews, analyzed by the Content Analysis technique in the Thematic-Categorical Analysis modality. ***Results***: the following categories were obtained << Factors that weaken the practice of Popular Health Education >>, << Guiding principles of the practice of health professionals of the Family Health Strategy >> and << Practices of Popular Health Education developed by the health professionals >>. ***Conclusion***: it is concluded that the practices of Popular Health Education developed by professionals in the Family Health Strategy are articulated with the principles of the National Policy of Popular Health Education. ***Descriptors***: Health Education; Family Health Strategy; Primary Health Care; Professional Practice; Community Participation; Public Policy.

RESUMO

Objetivo: compreender as práticas dos profissionais da saúde da Estratégia Saúde da Família a partir dos princípios teórico-metodológicos da Política Nacional de Educação Popular em Saúde, no âmbito do Sistema Único de Saúde. ***Método:*** trata-se de um estudo qualitativo, descritivo, com oito profissionais da saúde, por meio de entrevistas semiestruturadas, analisadas pela técnica da Análise de Conteúdo na modalidade Análise Temática-Categorial. ***Resultados:*** obtiveram-se as categorias << Fatores que fragilizam a prática da Educação Popular em Saúde >>, << Princípios norteadores da prática dos profissionais da saúde da Estratégia Saúde da Família >> e << Práticas de Educação Popular em Saúde desenvolvidas pelos profissionais da saúde >>. ***Conclusão:*** conclui-se que as práticas de Educação Popular em Saúde desenvolvidas pelos profissionais na Estratégia Saúde da Família se articulam aos princípios da Política Nacional de Educação Popular em Saúde. *Descritores:* Educação em Saúde; Estratégia Saúde da Família; Atenção Primária à Saúde; Prática Profissional; Participação da Comunidade; Política Pública.

RESUMEN

Objetivo: comprender las prácticas de los profesionales de la salud de la Estrategia de Salud de la Familia a partir de los principios teórico-metodológicos de la Política Nacional de Educación Popular en Salud, dentro del ámbito del Sistema Único de Salud. ***Método***: se trata de un estudio cualitativo, descriptivo, con ocho profesionales de la salud, a través de entrevistas semiestructuradas, analizadas por la técnica de Análisis de contenido en la modalidad de Análisis temático-categórico. ***Resultados***: se obtuvieron las categorías << Factores que debilitan la práctica de la Educación Popular en Salud >>, << Principios norteadores de la práctica de los profesionales de la salud de la Estrategia de Salud Familiar >> y << Prácticas de Educación Popular en Salud desarrolladas por los profesionales de la salud >>. ***Conclusión:*** se concluye que las prácticas de Educación Popular en Salud desarrolladas por profesionales en la Estrategia de Salud Familiar se articulan a los principios de la política Nacional de Educación Popular en Salud. ***Descriptores***: Educación en Salud; Estrategia de Salud Familiar; Atención Primaria de Salud; Práctica Profesional; Participación de la Comunidad; Política Pública.

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INTRODUCTION

The debate on health as a social right and state duty is defined[1] as a foundation for the construction of public policies, which reaffirm the commitment to the right conquered through the doctrinal principles of integrality, universality and community participation. It is known that this debate is present in national studies regarding the historical-political formation in undergraduate Health,[2] to popular participation in health education actions in the Family Health Strategy[3] (FHS) and in the defense of democracy from the social control of the Unified Health System (UHS).[4]

It is pointed out, within the framework of UHS implementation, that the social, political and economic contexts of the country, constituted by the inaccessibility of citizens to health services and the social mobilization anchored in the rescue of popular culture,[5] inspired advances in redemocratization during the 1980s. It is understood that social mobilization recognizes the need for changes in public policies and even the health practices developed so far. In this sense, the participation of the population in the struggle for the guarantee of rights and better living conditions is indispensable.

It is noted that the principle of community or social participation comprises, as regards health, the power in decision making by the subjects involved, transforming them from passive actors into active subjects.[6] It is stated that these meanings dialogue with the Popular Health Education (PHE) by crediting these subjects with the possibilities of expressive changes and autonomy for their participation in the formulation and control of public health policies.

Participation is considered as an inclusive and autonomous process, essential for the transformation of factors that impact the health of the population, especially the most vulnerable groups.[7] Despite the fact that health is understood as a product of determinants and conditioning factors - these being work, income, leisure, safety, among others -, in Brazil and the Latin American continent, there is an insufficiency in the processes of Community participation capable of enhancing the struggle for these determinants.[7]

It is known that the dimension and political practice pertinent to EPS have been built since the 1950s by Latin American intellectuals who sought to replace the elite's authority relations with the population, as they approached the popular world. The development of participatory democracy in UHS through the circles of culture and conversation circles is materialized as ways that stimulate the protagonism of new actors in the health sector.[8]

Among the intellectuals who contributed to the EPS, the Brazilian Pernambuco Paulo Freire presents himself, who, in his theoretical and practical production, outlines such praxis as contrary to banking education, passivity, subordination and authoritarian practices. Thus, the need for reorientation of these practices is evidenced by breaking with this type of methodology.[9]

In this context, PNEPS-UHS emphasizes that, by reaffirming the principles of UHS and the implementation of policies aimed at the quality of life associated with the reduction of social inequalities, the commitment to effective popular participation in UHS.[5] Popular Education is conceived as the most identified and respectful political-pedagogical praxis towards the diversity of Brazilian popular culture,[8] and reinforces the proposal to change the paradigm in health praxis, in the reorientation of care that surpasses the biomedical model and establishes new relationships between professionals and users of health services.[9]

Therefore, the PHE recognizes as intentionality the autonomy of people and the encouragement of critical awareness, the exercise of participatory citizenship and the overcoming of social inequalities and all forms of discrimination, violence and oppression.[5] It is argued that these assumptions point to a practice beyond health education and contemplate a stance against the existing system of oppression and social exclusion in the country.[5] It is pointed out that its theoretical and methodological bases include philosophical, political, ethical and methodological dimensions that give meaning and coherence to the praxis of PHE,[5] having as its principles: dialogue; the lovingness; the problematization; the shared construction of knowledge; emancipation and commitment to building the democratic and popular project.

However, the persistence of challenges regarding the implementation of PNEPS in UHS is identified.[9] In a study on the practice of PHE developed within the scope of Brazilian primary care, it was warned about the importance of producing new research that can identify and reflect on the practices that have been developed under the popular education methodology.[10]

Thus, this article presents itself when considering integral and participative care, prioritizing the family in its territory, as well as the bond, reception, prevention and health promotion actions, treatment and rehabilitation,[11] having, in the Family Health Strategy (FHS), its locus of care, and by reaffirming the UHS guidelines, as well as the commitments of PNEPS-UHS, as a research object, the practices of FHS health professionals from the principles theoretical and methodological aspects of PNEPS-UHS in a Basic Health Unit (BHU) in the city of Rio de Janeiro (RJ).

OBJECTIVE

- To understand the practices of health professionals of the Family Health Strategy from the theoretical-methodological principles of the National Policy of Popular Education in Health, within the Unified Health System.

METHOD

This is a qualitative and descriptive study, [12] conducted in a Basic Health Unit in the city of Rio de Janeiro (RJ), which has five family health teams. It is noted that the participants were health professionals working in the referred teams of this unit, reinforcing the teamwork proposed by the strategy.

As inclusion criteria, health professionals with at least six months of work in the FHS of the unit under consideration were considered. Professionals who were on vacation or on sick leave or any other reason during the collection period were excluded.

Information was collected between September and October 2018, through a semi-structured interview applied to eight professionals, two nurses, two doctors and four nursing technicians, who accepted and made schedules available to participate in the study. It is noteworthy that, of the ten health professionals who worked for more than six months in the FHS, two did not provide hours to participate in the interview. Interviews were conducted at the health unit's premises, in a reserved place, aiming at the comfort and privacy of the interviewees. It is reported that the interviews lasted an average of 11 minutes, were recorded in MP3 format and later transcribed by the researchers.

Through the data collection instrument, questions were initially asked about training and knowledge about PHE: "Have you done any training about PHE? And about PNEPS-UHS?"; "Do you know PNEPS-UHS?"; "Do you know the principles of PHE? Which ones?" and "How are these principles present in your practices?" He then asked himself: "For you, what is problematization? And in your daily practice of the FHS?"; "For you, what is shared knowledge construction? And in your daily practice of the FHS?"; "For you, what is dialogue? And in your daily practice of the FHS?"; "For you, what is lovingness? And in your daily practice of the FHS?"; "For you, what is emancipation? And in your daily practice of the FHS?" and, "For you, what is your commitment to building the democratic and popular project? And in your daily practice of the FHS?".

Prior to the interviews, the two-way Free and Informed Consent Term (FICT) was signed. The data collection was completed by data saturation and the maximum number of participants, according to the inclusion and exclusion criteria. The information was worked by the technique of Content Analysis in the Thematic-Categorical Analysis modality, by the following steps: floating reading; definition of provisional hypotheses about the object studied and the text analyzed; determination of the Registration Units (RU), understood as the smallest unit in the text that is assertive about the object under study, and may be a word, sentence or paragraph; definition of meaning units (MU) and construction of themes; constitution of the categories, based on the themes arising from the interviews; discussion of results and return to the object of study.[13]

The recommendations of the National Health Council Resolutions 466/12 and 580/2018 were respected regarding the ethical aspects of research involving human beings. The research was approved by the Research Ethics Committee (REC) of the Federal University of the State of Rio de Janeiro, under the opinion 2.699.399, and by the REC of the Municipal Health Secretariat of Rio de Janeiro, under the opinion 2.850.234. . The anonymity of the study participants was preserved by identifying them with the letter “P” followed by numbering in order of collection.

RESULTS

Seven interviewees were female and one male, and the age group was between 24 and 69 years old. It is known that six participants had completed higher education and, of these, four had specializations - two in Family Health, one in Health Promotion and one in Collective Health. It is reported that working time in the unit ranged from one to eight years and, in the FHS, the time ranged from one to 11 years of work.

When asked if they had already done training in PHE, five answered no and three answered that they already participated, all referring to the work as provider of this training. Regarding the training on PNEPS-UHS, the eight participants stated that they had not been trained on the policy at any time. Regarding knowledge about PNEPS-UHS, three said they knew, four said they did not know and one said they knew “more or less”. It is noteworthy that, of the three participants who said they knew about politics, all referred to university education as the learning space.

In the empirical corpus of the interviews, 198 RUs were grouped into 26 MSs. From the MSs, three thematic categories were obtained, namely: Factors that weaken the practice of PHE; Guiding Principles of FHS Health Professionals Practice and PHE Practices Developed by Health Professionals.

♦ Factors that weaken the practice of PHE

The factors that weaken the practice of PHE in the FHS are evidenced by describing the difficulties encountered in the daily routine of the

health service. In this category, 16.6% of the RUs are added in three themes: difficulty in building care with users through listening and dialogue; difficulty in solving the problems identified and the conjuncture of the work process in the FHS that hinder the practices guided by the PHE. It is indicated that these themes demonstrate what hinders the daily practice of PHE, as represented in the following statements.

> *[...]Not everything we say people understand. So we have to know [...]. Have a waist game to talk to that user so they can understand. (P08)*
>
> *We are offering a certain service here, with a lot of enthusiasm and what they [users] would like, actually, is another, and we don't know, we are closed to listening to this. (P04)*
>
> *[...]and really, when we sit, sometimes the CHA, or even, we are in that race, we don't listen to the patiente […]. (P07)*
>
> It is understood that the difficulty in dialogue with the population seems to come from health professionals, and the length of work in the FHS is presented as a challenge to the practice of PHE.
>
> *[...]sometimes professionals, who have been in this for so many years[...] who are already accommodated [...] and then, for you to sit down and build something with these guys, it's very difficult. (P01)*

In the face of the challenge of experiencing the health unit, the difficulty in solving the identified problems was also reported, either in the appointment scheduling process or in the lack of inputs, the professionals' multifunctionalities, the inadequate infrastructure, the workload. flexibility, in addition to existing bureaucracy, even in everyday situations. These problems were associated by the research participants to the conjuncture of the work process in the FHS, which weakens the practices guided by the PHE, as follows.

> *We have a problem to solve and we can't. For example, the patient is sick, the medication is missing, the specific doctor is missing [...]. (P02)*
>
> *The bureaucracy, which is too big to solve simple things. (P06)*
>
> *They complain a lot about the difficulty to make an appointment. (P04)*

♦ Guiding principles of the practice of FHS health professionals

In this category, from 34.4% of the RUs are considered the expressions and values that guide the professional practice in the FHS, and they are presented what are, for them, the principles of PHE. Expressions such as listening to the patient, co-responsible about their self-care, understanding their demands, meeting with care, affection and respect and sharing knowledge, as described in the following RU, were recognized.

> *That's when we give importance to what the user knows, to what the user brings and we try to create strategies using the user's knowledge, also, giving importance to it. (P05)*

It is pointed out that the co-responsibility of the user was a remarkable expression in the participants' report, reaffirming the importance of including them in the decisions of their therapy and in the care they develop, in addition to meeting the health professional, as observed in the following study.

> *You make the user co-responsible. [...] the user understands that this is not something that we, as a professional, will be able to handle alone [...] how to take care of him. (P01)*
>
> *Sharing responsibility [...] does not want to hold only the professional or the patient responsible. (P03)*

Also noteworthy is the meeting between the professional and the user as a loving practice, when it is placed to understand the user's experience and reality, not judging and seeking empathy when building alternatives for health care.

> *It's you putting yourself in the place of the next one, that person who seeks care, [...] I think being loving is putting yourself in the other's place. (P06)*
>
> *I see it in your ability to put yourself in someone else's shoes, try to understand their experience. (P04)*

The acts of sharing and / or exchanging knowledge were related as a constant principle in the practice of the FHS, which dialogues with the importance of the user's knowledge, considering that not only the professional or the user has the unique knowledge or truth.

> *Every day, we share information and knowledge, right, we are exchanging ideas with each other [...]. (P02)*
>
> *Especially in the strategy, we are always sharing knowledge. (P07)*
>
> *Give credit to what the patient is giving you and not treat as an alienated person [...]. (P06)*

However, in two interviews, the expression "transmitting knowledge" was reported as a principle of popular education practice, which refers to the biomedical and banking education model[9] mentioned above. In the following examples, passing and putting knowledge to the other as a way to educate themselves in health are presented.

> *We learn and pass on to people what we learned later [...], you also pass on all that you know, pass on to him. (P07)*
>
> *So, I put a lot of my knowledge so [...] I can help, help the person who needs my help. (P08)*

♦ PHE practices developed by health professionals

This category emphasizes the practices mentioned by the participants as daily and recognized as PHE, composed by 48.98% of the RUs. We identified the practices in PHE performed

by professionals through their speeches: listening to the patient; talk; recognize problems and seek solutions; practice with multiprofessional team; guide the user and open to discussion with the population.

It is understood that the practice of guiding the user is present in four of the eight interviews developed. A description of a respectful practice from the user's life territory is presented. However, it is noteworthy that the statements mention situations in which the user does not accept the guidelines shared by health professionals. Nevertheless, it was outlined as a practice of respect and acceptance, aimed at the construction of knowledge with the user, even when the user opts for the refusal to orient health professionals.

> *If you reach out to a person who will not take into account what you guided at that time, you will not stop guiding, trying to build something. (P01)*
>
> *User guidance on the health issues they are inserted. (P04)*

The practice of a multiprofessional team in the participants' speeches is valued, highlighting the multiprofessionality for the production of health care and work processes, as well as the support to seek solutions proposals in the collective of the plurality of professions.

> *It's like we use another type of access, like, when I do interconsultation, when I do a joint service with a professional from another area. (P05)*
>
> *And sometimes, the case of one, that a health agent, or a doctor, or a technician that professional [...] passed by [...] he has how to pass us, sit, talk. (P07)*

It was noted that the participants mentioned the importance of having channels of dialogue and conversation with users. However, it was evaluated as important as speaking, listening to the user, letting them talk openly about their demands, knowledge and proposed solutions. This creates the opportunity to open a discussion between professionals and users. Openness to discussion produces agreements through subject choices, which modifies health practices and enhances harm reduction attitudes.

> *It's talk [...] that I do well, talk. (P03)*
>
> *It's you listening to the patient [...] it's not just you talking, it's you being a listener, listening to everything he has to say. (P07)*
>
> *Listening to the patient. [...] the dialogue for me in the FHS is to listen. (P06)*

Participants mentioned the importance of building practices that value user participation and collective construction, integrating the knowledge and experiences of the multiple social actors that make up the FHS - users, team professionals and social references through a practice of openness to the population.

> *You can't take into account just what you think, what the other person thinks, you have to go to the collective to build something, right, that's good for everyone. (P01)*
>
> *[...] people come here, they talk what they think, many people attend that meeting I just talked to you from the board, [...] and there they put their difficulties, they give you ideas, they give opinions, give examples of their lives. (P02)*
>
> *[...] bring them here, users here, for them to participate in everything, for them to have access to everything they can access and to participate with us, first, to participate with us in everything. (P07)*

DISCUSSION

From the analysis of the interviews, we highlight the lack of approach of the participants to the PNEPS-UHS, since only three of the participants said they knew the policy. This corroborates the studies that point out limitations regarding the knowledge about PHE and the need for formation of human resources with property on the theoretical and methodological foundations present in politics.[10,14-5]

It was identified, in a study developed with students of the last year of the undergraduate Nursing course of a federal university in Brazil, the deficiency in the perception of the students about the popular education and its applicability. It is emphasized by the authors that training that does not promote education, does not stimulate reflection on PHE and does not apply policies is the same training in health as traditionalist and banking education.[14]

The authors defend health professional training through curricular reform based on theoretical and methodological aspects of PHE through small movements that result in the expansion of technical competence, critical awareness and autonomy of the future professional.[16]

Regarding the factors that weaken the development of PHE, the lack of knowledge, the difficulty of the user to understand and the non-acceptance of the population regarding the guidance of health professionals were reported as some daily difficulties encountered by the participants. Non-comprehension by users was pointed as an obstacle to the shared construction of knowledge, although the importance of this principle was identified in the daily practices.

The construction shared by communicational and pedagogical processes between people and groups of knowledge is characterized, from the perspective of understanding and, collectively, transforming health actions into their theoretical, political and practical dimensions.[5]

It is noteworthy that authors from the field of PHE draw attention to what presents itself as the crisis of interpretation by health professionals,[17]

where they identify that the difficulties are user-centered, blaming them for not understanding and even rejecting the guidelines.

It is emphasized, however, that there is no reflection on how professionals themselves construct knowledge, what realistic methodologies and approaches develop, and how they update or adjust their modes of health care so that care is inviting and understandable for that community. Controversially, it is observed that the lack of knowledge and the lack of population were pointed as stimulating for the practice of PHE in other studies.[18]

It is inferred, however, by the report of the health professionals of this research, that, even identifying the difficulty of not knowing the user, still, agreements should be sought. Conversation, for example, is used through agreement as a power for a harm reduction attitude. Harm reduction for respondents is intended to build health care that respects the choices of the subject while at the same time not neglecting the guidelines of professional responsibility. In this perspective, the practice of harm reduction was identified as a practice of PHE, by identifying users' knowledge and their lifestyle and territory.

It is noteworthy that, through these agreements, there is the exchange between what is called in the PHE of scientific and popular knowledge, being essential to identify the ways that favor the articulation between this knowledge, and to update the traditional view that the user should comply with the scientific knowledge transmitted by professionals, with a view to building more effective and comprehensive care practices.[19]

It is noticed that the obstacles in the daily practice, such as the difficulty in making appointments and the lack of inputs, as a hindrance to the practices of the PHE, dialoguing with the moment in which setbacks and risks to UHS in the political-economic scenario of the country are allocated. It is argued that, in an alleged flexibility, the National Policy of Primary Care (NPPC), legitimized by cuts in health investments through Constitutional Amendment No. 95/2016,[20] It allows the workload of FHS professionals to be relaxed, allows professionals to work in multifunctions and investments are reduced for the acquisition of materials and conservation of spaces of health facilities. All these factors were highlighted by the professionals who experience the FHS as weaknesses for the full development of PHE activities.

It is revealed that the places of PHE practice were not clearly spelled out. However, the meeting between the professional and the user in the scope of the medical or nursing consultation and the groups for guidance, especially in the lines of care of systemic arterial hypertension (SAH), Diabetes Mellitus (DM) and smoking, were analyzed. It is noteworthy that home visiting (HV) was not mentioned as a place of popular education practices.

HV can be understood as a time when the professional can be close to the reality of the community, being important for the construction of popular education, as it is the natural environment of users, as mentioned in a study developed in the district of Pavas, Costa. Rica, who sought to determine the knowledge and modification of people's lifestyles after HV.[21]

Another category that stood out in the analysis of the interviews is the guiding principles of the practice of PHE. It is stated that the principle of dialogue, present in PNEPS-UHS, is referred to when the speeches evidenced the sharing of knowledge and the valorization of the user's knowledge, recognizing that there is not only one knowledge over another.[5,19] Respondents refer to a horizontal and respectful relationship, appreciating previous experiences for the construction of new health practices.

However, the transmission of knowledge was cited as a practice that seeks to benefit others. Thus, it is delegated to the professionals who “hold” the knowledge, the power of decisions based on trust or even the impossibility of space for contestation.[22]

It is noteworthy that this form of education does not disagree with the principles that the PHE advocates, does not produce new ways of acting in health services and does not contribute to the expansion of critical knowledge about the reality of both subjects involved in the meeting.

It is important, when dealing with this relationship between popular and scientific knowledge in the search for dialogue, to problematize that there is a tendency of the population to delegate decision making to professionals, demonstrating a certain lack of autonomy. It is known, however, that, in reflecting on the construction of knowledge, popular knowledge comes from concrete, elaborated experience, unlike the construction of professional knowledge. Thus, it is understood, through PHE, that there is no major or minor knowledge, but different knowledge, [17] which can enhance shared decision making.

From this perspective, there were speeches directed to the shared construction of knowledge through the practice of collective construction and openness to discussion with the population / users, characterized by the speeches related to the search to understand and collectively transform the needs and situations recognized in the encounters between the subjects.

As for the practices developed during the participants' speeches, the centrality in listening

to the user is emphasized. It is a critical perspective of knowledge construction, starting from the insertion of new knowledge and listening.[5] It is noted that another practice identified in the analysis was the conversation, cited as a form of respect, love and empathy to the user, when he feels comfortable to express his feelings, wishes and desires.

Thus, it is observed the construction of dialogical relationships in the interviewees' speeches through the concern to problematize the territory of life of the population. The practices of recognizing problems and seeking solutions, such as the identification of the reality that challenges, its problematization and the elaboration of strategies to overcome the challenges through dialogue, which meets PNEP-UHS, by presenting problematization as the existence of dialogical relations in the critical analysis of reality.[5]

It is noticed the concern with the users' demand and also the reflection on their life - what is presented as care production. In a study conducted in Mexico, the understanding of the demands of users and living territory, together with proposals for change and identification of potentialities, were evaluated as important practices for quality of care and articulation with the community.[7]

This moment of meeting between the health professional and the user is described as a loving practice, permeated by exchanges and professional sensitivity to go beyond dialogue, as observed in PNEP-UHS[5], in presenting lovingness as a principle of PHE that seeks to go beyond dialogue based only on logically organized knowledge and arguments.

Another important aspect in the analysis of the interviews is the multiprofessional work as an aggregator of PHE practices in the FHS. These practices are outlined by the discussion of ideas and solutions from different perspectives, which contribute to the expansion and quality of care built with users. It is pointed out that these results, also found in an integrative literature review on PHE practices, demonstrate multiprofessionality as a major advance for the FHS. This is due to the potential to combine knowledge and knowledge and to serve the user in its multiple dimensions.[23]

It is assessed that the analysis developed in this investigation focused on social participation in the UHS. Social participation is presented as one of the UHS principles and as a strategic axis of PNEPS-UHS,[5] through social control and participatory management; However, it was not possible to observe the social participation of users and professionals in the control of health actions. It is understood that, in the analysis, the principle under consideration did not permeate the power in decision making and autonomy construction, and the perspective of these users to participate in the (re) formulation and control of public health policies was not mentioned.

Destaca-se que, apesar de os participantes mencionarem a importância de problematizar a realidade de vida da população para o cuidado em saúde e construir processos coletivos de reflexão e tomadas de decisões compartilhadas, tais práticas não foram descritas pelos participantes como práticas cotidianas na ESF de transformação da realidade e emancipação dos atores envolvidos.

Thus, it can be seen that the management to overcome the various forms of oppression, discrimination and violence suffered by the population, especially those on the fringes of society and public policies, was not identified in the interviewees' speech. It is assumed that the critique of reality enables movements that produce forms of emancipation of the actors involved, as proposed by PNEPS-UHS.[5]

In this context, it is emphasized that PHE materializes as a process of collective construction of knowledge produced from the critical perception of reality with a view to its transformation. It is understood that meeting with the population from the perspective of PHE can often lead to an educational and pedagogical action,[24] It is necessary to build collective practices that enhance popular education beyond health care practices and that permeate the transformation of reality.

Despite the difficulties mentioned by health professionals regarding the development of PHE, it was possible to identify principles of popular education, as well as popular education practices in the participants' statements. These are practices that translate the principles of PNEP-UHS into the daily routine of services.

However, it is considered that they need to be closer to the principles of social participation and to the commitment in the construction of the democratic and popular project, in a perspective of overcoming the prescriptive relationships, making the user an actor of their health and disease processes. [21] and reaffirming its commitment to building a just, supportive, democratic, egalitarian, sovereign and culturally diverse society.[5]

CONCLUSION

It has been shown that the PHE practices developed by health professionals in the FHS articulate with the principles of the PNEP-UHS, such as dialogue, shared knowledge construction, lovingness and problematization. However, it is necessary to reflect on the expansion of practices that enhance social participation and point to the construction of the democratic and popular project.

It is noteworthy that the participants did not mention the PNEPS-UHS as a foundation for their practices, reinforcing the need for updating in health education and, later, in the continuing education of professionals regarding teaching and reflection on PHE, its policy and its principles. It emphasizes the need for the formative processes associated with the reflection-action-reflection of the actors involved with the social and political inequities present in the country, as well as the instigation of the social actors directly affected.

In this study, there was a consonance between the difficulties recognized by professionals present in the daily life of the FHS and the successive cuts in this model of care, according to the articles that discussed this strategy. It is understood that these barriers, identified in the workload of health professionals and the lack of infrastructure, coincide with the current primary care policy.

Although these professionals resist the mechanistic practices of individual production, the difficulties encountered in the daily routine of health services that weaken health practices anchored in the principles of popular education are revealed.

Further studies are proposed that contemplate other professional categories that make up the FHS not contemplated in this study, highlighting the community health agents, considering that these are important actors of transformation and bond between the health service and the community from which they also are alspo a part of and experience the reality.

It is pointed out that this research had limitations regarding the study in a Basic Health Unit, which makes it difficult to generalize the findings to other social contexts; However, it presented potentiality in the discussion of the results from the PNEPS-UHS and the daily practice of health professionals from different categories.

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