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RESEARCH

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THE CONSTRUCTION OF EDUCATIONAL PRACTICES AGAINST-HEGEMONICAS: AN ANALYSIS OF THE INFLUENCE OF HEALTH POLICIES AND PROGRAMS

A construção de práticas educativas contra-hegemonicas: uma análise da influência de políticas e programas de saúde

La construcción de las prácticas educativas contra hegemonicas: un análisis de la influencia de las políticas de salud y programas

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ABSTRACT

Objective: the study's purpose has been to analyze the policies and programs that influence municipal health management in the ordering of health education practices and education in the health system. **Methods:** it is an applied social research with a qualitative approach that was performed in a city from the State of *Paraná*, Brazil. The collection and analysis of data were by two techniques, as follows: documentary research, with 47 municipal management documents; and interviews with 16 municipal health managers. The discussion followed the counter-hegemonic premises of Gramsci. The current ethical precepts were followed. **Results:** the following actions are influential in the educational practices in health: Family Health Program, National Humanization Policy, National Permanent Health Education Policy, Health Pact, National Health Promotion Policy, Family Health Support Center and Primary Health Care Qualification Program. **Conclusion:** the policies and programs are counter-hegemonic powers, inserting dialogism and problematization in health, however, their use is restricted to the scope of management.
Descriptors: Public policies, education, continuing, health education.

RESUMO

Objetivo: analisar as políticas e programas que influenciaram a gestão municipal de saúde na ordenação das práticas de educação em saúde e educação na saúde. **Método:** pesquisa social aplicada, qualitativa, desenvolvida em um município estado do Paraná-Brasil. A coleta e análise dos dados se deram por duas técnicas: pesquisa documental, com 47 documentos da gestão municipal; e entrevistas, com os 16 gestores municipais de saúde. A discussão seguiu as premissas contra-hegemônicas de Gramsci. Seguiram-se os preceitos éticos vigentes. **Resultados:** são influentes nas práticas educativas em saúde: Programa Saúde da Família, Política Nacional de Humanização, Política Nacional de Educação Permanente em Saúde, Pacto pela Saúde, Política Nacional de Promoção da Saúde, Núcleo de Apoio à Saúde da Família e Programa

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de Qualificação da Atenção Primária à Saúde. **Conclusão:** as políticas e programas apresentam-se como forças contra-hegemonicas, inserindo dialogicidade e problematização na saúde, contudo seu uso restringe-se ao âmbito da gestão.

Descritores: Políticas públicas, Educação continuada, Educação em saúde.

RESUMEN

Objetivo: analizar las políticas y programas que influyen en la gestión municipal de salud en ordenar las prácticas de Educación de salud y educación para la salud. **Método:** investigación social, cualitativa, aplicada se convirtió en un municipio en estado de Paraná, Brasil. La recogida y análisis de los datos fueron mediante dos técnicas: investigación documental, con los documentos de gestión municipal 47; y entrevistas con los directores municipales de salud 16. La discusión siguió las premisas contrahegemónicas de Gramsci. Siguieron los preceptos éticos. **Resultados:** son influyentes en las prácticas educativas en salud: Política Nacional de Programa de Salud Familiar, Política Nacional de Humanización, Política Nacional de Educación Permanente en Salud, Pacto de Salud, Política Nacional de Salud Promoción, Soporte Base De La Salud Programa De Calificación De Familia Y Atención Primaria. **Conclusión:** las políticas y programas son hegemonicas contra fuerzas, entrar en intercambio y preguntas sobre la salud, sin embargo.

Descriptores: Políticas públicas, Educación continua, Educación en salud.

INTRODUCTION

Education and health are closely related to social practices. Thus, in Brazil, health education is a social and political achievement, addressed in the Constitution of 1988, which expresses the attributions of the health sector in the education of professionals1,[2] - called education in the health system - and the community - named health education[3] - as guidelines of the *Sistema Único de Saúde (SUS)* [Brazilian Unified Health System], ensured by the Laws 8.080/90 and 8.142/90.[1,2]

Nonetheless, it should be emphasized that health education is under constant construction and is permeated by several health policies, programs, and actions directed by national and state management based on political needs, health indicators and national and international pacts[4]. Currently the most relevant are the National Permanent Health Education Policies[1] and Popular Health Education[2], which strengthened, respectively, the problematization and dialogism in health.

In this sense, these policies are coherent with concepts that integrate Gramsci's liberating and counter-hegemonic education[5], whose thoughts are based on dialectical historical materialism with a focus on the liberation of subjects through education, words anchored in dialogue and the reality conceived by the problematization, mediated by counter-hegemonic movements that build new realities.[5] Hence, it can be inferred that theoretical policies, programs, and approaches have the capacity to influence the logic assumed by health education.

Considering the aforesaid, the research was based on the following guiding question: What policies and programs have influenced municipal management in the ordering health education practices and education in the health system?

The study is justified by the need to better elucidate the construction of educational practices in health in the city, especially concerning dialogism and problematization, their hegemonic and counter-hegemonic forces. Its results will make it possible to understand the future perspectives of health practices through the movement of traditions and contradictions.

Therefore, the objective was to analyze the policies and programs that influenced municipal health management in ordering health education practices and education in the health system.

METHODS

This study is an applied social research with a descriptive-exploratory nature and qualitative approach. The data source was the documents and statements of managers, allowing the triangulation of data, both from the municipal health department, involved with the educational practices of a regional pole municipality located in the northwest of *Paraná* State, Brazil, from 2006 to 2015. This time frame is justified by the Health Pact, promulgated in 2006, which reorganized management practices in *SUS*[6] and supposedly influenced educational practices in health.

Data were collected and analyzed by two techniques: documentary research - which favored the observation of the process of knowledge evolution, allowing the dimension of time to be added to social understanding[7], and interviews - which were a procedural option for believing that knowing the story of a recent past can be facilitated through dialogues with actors involved in this process.[8]

The Municipal Health Department provided 156 documents related to the scope of the study. They were grouped according to each type. Then, they were pre-analyzed through readings: exploratory, selective, analytical and interpretative, showing five dimensions: the context, the author(s), the authenticity and reliability of the text, the nature of the text, the key concepts and the internal logic of the text. After this process 109 documents were discarded: 61 because they were prepared by federal or state agencies, 30 documents because they did not fit the objective of the study, nine files were removed because they refer to the same manual, four because the studies were prior to 2006 and five because they for not having date or author information.

Thus, 47 documents were selected for analysis, namely: three Municipal Health Plans, seven Annual Health Programs, seven Courses and Events Worksheets, nine Annual Management Reports, ten Educational Activities Reports, and eleven Protocols and Manuals. The selected documents underwent a review process of the units of analysis, and then, definition of the analysis categories during February and May 2015. The documents were identified by their initials, followed by the year of publication and page number of the which particular excerpt or segment has been removed.

For the selection of respondents, the 'snowball' technique was used, in which the initial participant was chosen for convenience, due to the close relationship with the focus of the study; then, he nominated the second respondent,

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who nominated the third, and so on, until the research objective is reached[9], all the guests agreed to participate in the study.

So, 16 central health managers who work at the municipal health department participated in the study, all female, within the age group from 31 to 54 years old (average 45.9 years old), professional training in health, including 10 nurses, 2 pharmacists, 2 psychologists, 1 nutritionist, and 1 dentist. Regarding the level of education, all professionals had *Lato Sensu* specialization and 4 had *Stricto Sensu* specialization, 3 at the master level and 1 at the doctorate level. The professionals performed the function of management or coordination of health programs, with working time ranging from 03 to 27 years (average 18.7 years).

The interviews took place during December 2014, using a semi-structured script, conducted in the workplace at previously scheduled times, with an average duration of 38 min. They were fully transcribed and analyzed according to the thematic content analysis, following pre-analysis steps, material exploration, and treatment of results.[10] They were identified with the letter I of the interviewee, followed by the Arabic number referring to the order of the interviews.

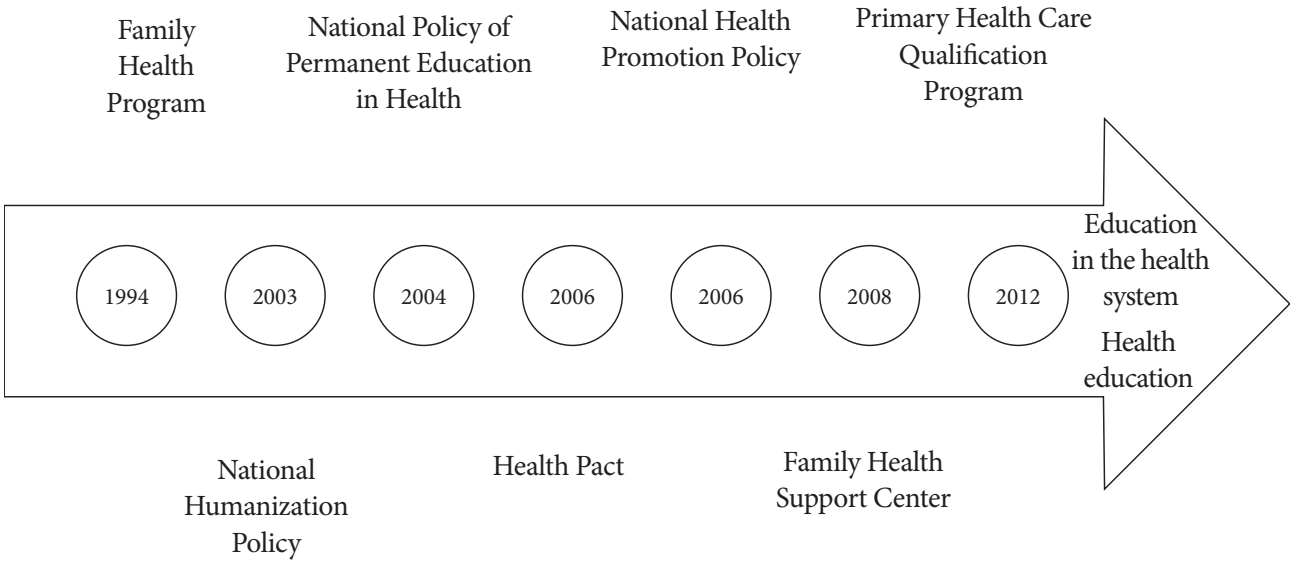
The analysis categories of the documents were grouped with the thematic categories of Bardin[10], resulting in the final categories of the study. The discussion of the data took place in the light of Gramsci's assumptions[4]. According to this framework, education is a political act, which promotes the change of paradigms and conceptions through subtle alterations, building counter-hegemonic, free, dialogic and emancipatory movements.[4,11]

The research followed all the ethical precepts of the Resolution 466/2012, Legal Opinion No. 897,950/2014 (*Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 38820914.4.0000.0104).

RESULTS AND DISCUSSION

The analysis of the interviews and documents showed several health programs and policies that influenced the construction of health education and education in the health system of the municipality. Thus, we present the main influences found, in chronological order (Figure I) that emphasize counter-hegemonic character.[5,11]

Figure I - Health policies, programs and actions that influenced the educational practices developed in a Northwestern municipality from the *Paraná* State, 2017.



Source: the authors.

The policies and programs that influenced health education practices were elaborated by the Federal Government and the State, directed to guide the work process of health professionals. These influences had repercussions on education in the health system as well as health education, because professionals are the intellectual actors in the thinking and health process with the possibility of transforming it. Therefore, all the orders of their care practices reflect on their knowledge and practices and, thus, their educational actions with the population.

In this framework, the Family Health Program (FHP), the current Family Health Strategy (FHS), was the first cathartic movement towards the transformation of the economic, political and social force towards the ethical-political yearnings of society mediated by the collective and by politics[5,11] of educational practices, according to managers:

> *I believe that a milestone concerning educational practices was the Family Health Program (FHP), because after its implementation here in the city, around the year 2000, there was a very big change, because before it was very focused on individual care and in the curative service [...]. From the FHP spread the thinking about community and people inserted in a broader context.* (I3)

The FHS was created by the Ministry of Health (MH) in 1994 and implemented in the municipality in question in 1999. It was presented as a new and counter-hegemonic way of acting in health, centered on the social reality of the community and territory, with prevention and promotion of family health as focus of attention to avoid the illness process and also fragmented care support.[12,13] Considering this strategy, the collective idea overlaps the individual and superstructure longings; The subject's world is the field of health practice and care, considering them as critical and social beings, influenced and influencing their environment.[4]

The intellectuals of the FHS (professionals and users) were the contributors. Their struggles, social and political, ensured a horizontal democracy, the basis of the counter-hegemony of the dialectic.[5,11] They established a new way of thinking and acting, and thus influenced health education.

Furthermore, the FHS significantly contributes to reorient the educational processes in health, because education is one of its pillars and by which it is possible to consolidate and improve the *SUS*, by allowing to expand the capacity of health care and self-care.[14]

For this, it must be developed based on a liberating and historical-critical approach, a dialogical, critical and reflexive educational model that gives voice to those involved and stimulates the development of new intellectuals, fundamental for ideological change.[5]

This new model of health care led to new reflections that allowed the letter to the National Humanization Policy (NHP)[15] that aims to reduce the processes of exclusion in health and bring work closer to the needs of the population, in a dialogic, critical and empathic manner. Its adoption is found in the following excerpts:

> *Implement the Municipal Humanization Policy in accordance with the guidelines of the National Humanization Policy* (PMS 2006-2009, p.43)

> *Education within the service is compulsory, following the premises of the Humanization Policy.* (I2)

The NHP, developed in 2003 by the MH[15] and in the present municipality in 2006, broke with the hierarchy of hegemonic super-structural power and considers all social beings, regardless of their class in the health structure, as an intellectual being capable of reorganizing culture and ideology in order to make them, counter-hegemonically, a process based on contradiction, the collective and reality.[5]

The focus of NHP is to overcome the oppressive forces of the process that hinder the construction of the *SUS*, aiming to problematize the management of health services and, therefore, the work processes. They assume equal participation in work process decisions of managers, professionals and users alike.[15] It contradicts the hegemonic models of care and management, marked by authoritarian and centralizing practices, empowering and creating spaces of exchange by assuming that people with different values, knowledge, habits, desires, interests and needs collectively find ways out of everyday challenges.[5,16] That said, they consider users to be political and social beings, capable of contributing to the ethical-political change of health.[5]

In order to stimulate the collective and transformative potential of professionals in the face of new health policies, as these are the actors capable of concomitantly altering ideology and action in health, breaking the superstructure hegemony,[5,17] developed in 2004 by the MH, the National Permanent Health Education Policy (NPHEP),1 implemented in the municipality in 2006, as shown below:

> *General guidelines for the management and organization of services: [...] Adopt the policy of continuing health education in training; [...].* (PMS 2006-2009, p.43)

> *Developing a Permanent Health Education (PHE) plan for SUS workers within the Municipal Health Department.* (RAG 2014, p.48)

It should be noted that the policy mentioned above, despite being the most influential in the field of health education, only emerged in the documents analyzed. In the speeches of the managers were presented only suggestive sections to it. Therefore, it was shown that the changes are in the managerial plan and were not adhered to by the mass, as much as it may have come from their yearnings and to change their practice. Policies and programs do not have the potential to change conceptions only by their creation and implementation, it is necessary the adhesion of those involved, and for this the premises of their ideology must be based on the reality of the collective.[5,18]

In this sense, the first version of the NPHEP, 2004, provided for hegemonic and traditional actions of integration between management, academia and health services, to create education centers, still in the logic of training and away from the reality of the workplace, giving in to social movements, but still imploding a little emancipatory ideology[5,17] which may have removed this policy from professionals.

Only in 2007, politics counter-hegemonically inserted the criticality, the problematization and the dialogism as guiding the educational practices with the professionals. To be effective, education must be outlined in and about reality, preferably by the professionals involved, valuing their knowledge and practices and the problems and solutions raised by them, to develop a meaningful and transformative educational process5. This movement allowed the construction of a new structural culture and those involved as intellectuals and formulators of transformative actions.[5,18]

Another program influential in educational activities, but effectively focused on the autonomous management of the municipality, was Health Pact, as excerpts:

> *I think everything is embedded as an educational practice: the prevention and promotion actions, the indicators and procedures themselves, the goals, the objectives of the Pact. They all point to the implementation of educational actions.* (I15)

> *The actions to be defined in this plan must also include the proposals approved at the Municipal Health Conference and meet the priorities defined in the "Health Pact", established by Ordinance 399/06 of the Ministry of Health.* (PMS 2006-2009, p.22)

The Health Pact was developed by the MH and implemented in the municipality in 2006. It is subdivided into three chapters: Pact for Life, in defense of *SUS* and its management. It has a close relationship with management and education, in particular, the Management Pact, which sets goals and guidelines for improving management, work regulation, health education and fostering participation and social control.[6] It inserts counter-hegemonically to education in a formal and systematized way in the context of health management, changing the current ideology of educating itself to pre-defined themes for when problems emerge, broadening the ethic-political-social conception of education and work[5]. The Pact in Defense of Life deals with preventive and health-promoting actions,[6] distinct from the hegemonic curative care and in the same way that the other pacts add new ideologies to knowledge and health.

Thus, the Health Pact and its chapters break with the verticalization of management, inserting horizontal and participatory democracy, through the contradiction of knowledge and power by the insertion of the mass - its data and indicators - for the delineation of collective health actions, as the excerpt below:

> *The Pact came for us to organize by focusing on local priorities and [...] for that we needed this permission, autonomy and the management to want to participate. The Pact brings the goals and focuses that the municipality needs to achieve and to do all this the municipality needs partners, community collaborators to make this happen effectively.* (I2)

The autonomy to plan with community data allows giving visibility to the people and the problems situated in processes of social and ideological exclusion that manifest themselves in different ways in different communities. Moreover, understanding the need for partners - usually organized civil society and other social structures such as schools, associations - to realize health actions break with the hegemonic logic of health as an individual object and unrelated to social, political and economic determinants.[5,19]

From the counter-hegemonic comprehension of health determinants and the focus on maintaining healthy individuals, the National Health Promotion Policy (NHPP),[20] which is referred to since the *PMS* 2006-2009, was catalyzed as a structural axis for the development of educational practices, as shown below:

> *This plan was built in the context of the municipal government's proposal to institute health promotion as a guiding axis of public policy, from the perspective of a healthy municipality.* (PMS 2006-2009, p.07)

The NHPP was created in 2006 and since then, implemented in the municipality. This policy reinforces the counter-hegemonic view of health promotion, as a strategy to produce, think and operate in conjunction with other policies and technologies developed in *SUS*. Thus, it contributed counter-hegemonically to the construction of actions aimed at social health needs, focusing on the aspects that determine the health-illness process, although timidly. Hegemonically, health approaches develop from an individualizing and fragmentary perspective, and make subjects and communities responsible for their illness.[13,20]

Contradictorily, the NHPP encourages the strengthening of citizens' protagonism.[20]

NHPP is developed within the scope of health management, to bring the actions of professionals and the population closer together. To implement it, new health professionals were necessary to corroborate the economic and corporatism struggles while building comprehensive health.[20,21] For this purpose, the Family Health Support Center (FHSC) was created, according to the following quotes:

> *The implementation of FHSC contributed greatly to the implementation of the work process within the units, allowing reflections among the team about the main local health problems and the agreement to reach the goals, although still incipiently, and this process needs to be matured. In the next years.* (RAG 2010, p.53).

> *The Department of Health has sought the gradual implementation of Permanent Health Education (PHE), mainly through FHSC professionals, [...]* (PMS 2014-2017, p.33)

The FHSC is composed of a multi-professional team, created by MH[22] and implemented in the municipality in 2008. Its purpose is to support and integrate FHS professionals by expanding their care reach. To this end, it counter-hegemonically promotes the development of spaces for the production of new knowledge and the expansion of the clinic, stimulating the development of educational groups in the community to spread and share knowledge and practices in health.[20,21] In addition to unveiling the problems and of possible solutions allows the collective, critical and social awareness of individuals.[5,17]

The FHSC allows communities and professionals to have voice and visibility through the problematization of the current hegemonic cultural and social sphere, breaking with the forging practices of freedom and immediacy[23]. Strengthens the mass - professionals and users - for lasting and universal struggles; struggle capable of counter-hegemonically transforming health into knowledge and practices that promote and prevent.[5]

Catalyzing these movements that insert the population in health, the MH developed in 2012 the National Popular Health Education Policy[2] to intensify and qualify the educational actions developed with the population. However, it was not markedly present in the speech of any interviewee nor the documents analyzed, so it is not mentioned in Figure I. It was only possible to verify its subtle presence in some speeches:

> *Health education with the population has no time, no place and it does not have who will do it, even in the corridor I can approach a person, I can make this contact with them, identify any need.* (I1)

> *The educational practice is in your daily life, in your conversation, in your welcome, in the form of assistance.* (I14)

Therefore, the concepts of popular education are mentioned in the speeches of managers and analyzed documents, but they do not assume the use and influence of the National Popular Health Education Policy, as it is not clearly mentioned, as they did with other programs and policies. It can be inferred that the lack of clarity of the National Popular Health Education Policy in the official documents analyzed is justified by the fact that it is a relatively recent policy and has no normative and directive character. Nevertheless, because it is anchored in a philosophical and reflexive conception of health and social practices[2], it would be relevant that it was ordering health education in the municipality to bring together transformations in educational practices among the population.

This counter-hegemonic policy allows professionals to reflect and rethink their educational processes without inducing them to develop a particular action. It directs practices without imposing ideologies and cultures; on the contrary, it aims at valuing popular knowledge and practices, giving citizens the role of considering them historical and social beings, encouraging horizontal and critical democracy, and highlighting popular ideologies.[5,17] Thus, its effective implementation is of great value in counter-hegemonic consolidation of various health knowledge and practices.

Finally, highlighting for promoting the experience of an active and problematizing education, the analyzes point to the *Programa de Qualificação da Atenção Primária à Saúde (APSUS)* [Primary Health Care Qualification Program], presented in the excerpts:

> *The adhesion of the municipality to the Master Plan of Primary Care of the State of Paraná through APSUS, for training and qualification of primary care professionals, has provided a reflection and implementation in the work processes of teams, in the practice of continuing education.* (PMS 2014-2017, p.33)

> *APSUS are workshops that took place, [...] where we plan knowledge and talk about concepts. We integrate the professionals of primary care, urgency and emergency, mental health. New protocols were discussed, and all built and sent to the state how professionals in Maringa think of building health networks. [...]* (I1)

APSUS is a program developed since 2012 by the State Department of Health of the *Paraná* State to reorganize Primary Health Care and implement Health Care Networks.[24] Its actions, following a hegemonic model, are still divided into life cycles with biomedical view of the health-disease process, but with regard to the management of educational activities in health, it stands out for its reflective, practical, horizontal approaches based on the reality of the service,[11] consistent with the premises of permanent education.

This program allowed the construction of a new concept of education with professionals, based on the valorization of local and professional managers, to decentralize and dilute the dominant forces and power relations.[5,25] This allowed the structure of the superstructure to be altered, so that the oppressive and passive force - actions of the state - turned into dialogic, liberating and critical decisions.[17]

In addition, the implementation of *APSUS* allowed a real integration between service and academia through a reflexive and transformative movement, making possible the formation of critical-reflexive professionals, whether undergraduates or graduates, capable of acting counter-hegemonically in practices, which, being social in nature, they always become obsolete and necessary for transformations and in order to stop becoming hegemonic,[5] leading to effective and progressive changes in the health care model advocated by *SUS*.

In short, it should be noted that the analysis of this historical course has led to the understanding that the reorientation of the official discourse on health education and education in the health system has made it possible to insert with critical progress, but not without stagnation and some setbacks, the critical reflection on reality, dialogue and community empowerment. Thus, the education that the municipality intends to implement aims at the theoretical level, no longer the maintenance of ideological elements, but the critical-citizen formation of people, whether professionals or users - so that they become able to intervene autonomously in the social reality. This is proposed by health policies and programs.

CONCLUSIONS

Educational practices are being built influenced by ministerial and state guidelines aimed at the consolidation of the Unified Health System. The Family Health Program was a pioneer in catalyzing practices directed to the specificities of the community, followed by the National Humanization Policy that values the knowledge and practices of health professionals and the population.

The National Permanent Health Education Policy in was directed to the qualification and valorization of the professionals, considering them as active intellectuals of the change health process who, along with the Health Pact, valued the education in the health scope, besides reorganizing the health service based on strategic areas and population needs. In this context, the National Health Promotion Policy followed the strategic areas focused on the quality of life, but still very focused on health prevention.

All these policies, programs and actions brought dialogue and problematization closer to educational practices, considering the general people - health professionals and population - as social beings capable of ideologically inserting their knowledge and practices to transform health actions and build new and effective ways of taking care. However, such acts are marked by the indoctrination of health management professionals with incipient leadership for the necessary changes.

After the implementation of the Family Health Support Center - developed for both health professionals and the population - and the Primary Health Care Qualification Program - which focuses on the reorganization of Primary Care in the State - dialogism and problematization began to be debated and subtly used in the planning and implementation of educational activities in order to enhance the knowledge and practices of professionals and the population.

All these actions made it possible to understand other ways of carrying out educational actions and to reevaluate their organization. Bearing in mind the aforementioned, even if the municipality is still unable to fully carry out educational activities with the premises of dialogism, collective construction, problematization, and empowerment, it is still supported by various actions and programs.

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