

# Health Promotion and Critical Education

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## ABSTRACT

This paper discusses Health Promotion and Critical Education, and seeks to show the theoretical and conceptual interfaces between them. It indicates the transformation and supersession of different health education models and their relationships with the health-disease process and health promotion. Based on these distinct health education models, it points out the implications that the directions within pedagogical practice and the knowledge produced through education represent for individual and collective health. It puts the discussion into context by analyzing seven international documents: Letters and Statements on Health Promotion, which were released by the World Health Organization and by the Pan-American Health Organization, between 1986 and 2000. Points that emphasize education within this specific field are highlighted. It is concluded that in order to implement the proposals contained in these documents, the contributions of Critical Education are necessary and essential for promoting health.

**Keywords:** Health Promotion. Critical Education. Health Education.

## Initial remarks

The first studies on health promotion correlated the causes of diseases with the living conditions of populations. At the same time, they advocated the idea that health problems presented a relationship with the nature of community life. The origin of illnesses and experiences of health and becoming ill were correlated with environmental causes. Thus, disease causality was combined with the physical and chemical quality of the environment (Buss, 2003; Chor and Faerstein, 2000).

In the 20<sup>th</sup> century, a paradigm for explaining disease occurrence known as the biological paradigm emerged. Its rise can be correlated with the growth of capitalism and urban communities and with the development of science, which has generated advances for coping with pathological conditions that until then were uncontrollable and untreatable. Through the evolution of investigations within this field, the mysteries relating to contagion and transmission have been unraveled, now under the aegis of bacteriology as a science. A new definition for the origin of diseases has emerged, which correlates their existence with the presence of etiological agents inside the host's body (i.e. the human body), and no longer with living conditions as health determinants. Thus, healthcare actions

in relation to the environmental and living conditions of the population shifted towards preventing and combating specific agents: microorganisms (Rosen, 1994).

This model has resulted in reduced and insufficient comprehension of the entirety and complexity of the health-disease phenomenon, given that it does not recognize social, cultural and ecological factors. In this manner, as well as neglecting knowledge that could be appropriated from other fields, it also creates distortions in resource application and use.

From an educational point of view, the knowledge produced over this period (the bacteriological era) is represented by health education actions that take an authoritarian and coercive focus, with the aim of standardizing hygiene habits and disciplining workers and the urban population. This consists of a project for standardizing behavior and attitudes, with the aim of ascribing rules for good living to people who become considered to be a set of individuals. Health education is shown to be a form of prevention, especially for diseases that do not have any specific treatment, and its actions take on the character of “sanitary policing”, with a view to molding sanitary awareness among individuals with diseases (Oshiro, 1988).

This reduction of the health-disease process to biological comprehension of this phenomenon puts individuals into the position of being responsible for their state of health. Thus, the relationship between the population’s living conditions and diseases takes a secondary position, which favors the understanding that pathological conditions result from people’s ignorance, lack of knowledge and moral decadence. It therefore becomes necessary to educate the population with the aim of controlling and disciplining their hygiene behavior and instilling healthy living habits so that people may incorporate the values imposed through expansion of the economy in urban centers (Oshiro, 1988).

Starting in the 1970s, public health thinking underwent restructuring such that a new phase began, highlighting the idea of reciprocity between the multiple dimensions that condition the health-disease process. One of these thoughts is expressed in the Lalonde Report, published in 1974 (Lalonde, 1974). To comprehend health problems, this document proposed interfaces between four components: human biology, environment, healthcare organization and lifestyle. Furthermore, it was the first time that a government document had used the term health promotion as a strategy for formulating intervention policies.

With the aim of explaining the health-disease process as resulting from mutual relationships between various living organisms and the environment, Leavell and Clark (1976) proposed the model known as natural history of disease, which was conceived within the idea of multiplicity of causal factors. In this model, diseases can be combated according to three different preventive levels, depending on the degree of knowledge of the natural history of the disease: primary, secondary and tertiary prevention. Within this context, health promotion is expressed through actions by healthcare professionals aimed at environmental and individual risk situations, which might contribute towards avoiding occurrences of a pathological condition (Arouca, 2003; Buss, 2003). At this point, it needs to be emphasized that the pedagogical direction of educational practice is limited to avoiding the bad effects or risk of becoming ill.

Even though the Lalonde document and the national history of disease model have enabled advances in comprehension of the health-disease phenomenon, the biological, social, political and environmental factors that have become used to explain occurrences of illnesses appear fragmented and disconnected from the subjects’ overall socioeconomic and cultural context. In this manner, the predominance of the biological viewpoint is still maintained, despite the recognition that health also involves aspects of the social and cultural processes of individuals and communities (Lopes, 2000).

However, through the First International Conference on Health Promotion in 1986, the discussions on this topic gained new wind. From this meeting, the Ottawa Charter was published. Even today, this remains a fundamental document for development of the ideas behind the proposals debated at that conference and a reference point for formulating public policies (World Health Organization - WHO, 1986).

According to the Charter, the notion of health promotion takes health to be a resource that individuals have and which, along with other means offered by society, should be used for their full development and should not be treated as an objective to be reached only when individuals are ill (PAHO, 1996; WHO, 1986).

This conception implies increasing people's capacity to make use of their existential resources, taking healthcare concepts to be comprehensive and no longer in terms of their specific characteristics. Moreover, it correlates with the possibility of shaping critical awareness that would have the capacity to provide infrastructure for subjects' autonomous decisions, rather than through uncritical acceptance of standards and conduct imposed by the sanitary authorities, in either a covert or an openly admitted manner.

Thus, the concept of health promotion includes a wide spectrum of factors and determinants relating to quality of life, such as: a stable ecosystem, peace, adequate dietary and housing patterns, chances of work, opportunities for education throughout life, social support both for individuals and for family groups, healthy lifestyle, sustainable resources, and so on (Buss, 2003; PAHO, 1996; WHO, 1986).

It can be stated that health can no longer be understood only from the field of healthcare itself, and that its promotion depends on broad action that takes into consideration all of the elements that are essential for increasing quality of life and a sense of active citizenship. In this manner, active citizenship can be said to be related to the idea that has been formulated since the end of the 20<sup>th</sup> century regarding so-called third-generation rights (Vieira, 2000). These comprise not only individuals' rights but also the notion of the collective ethics of humanity itself, in addition to the civil, political and social rights that have been achieved and taken on by societies throughout history.

It becomes necessary to reflect on how to construct fundamental educational knowledge for health promotion, conceived in such a way that individuals and groups achieve emancipation, autonomy and critical reflection, in which dialogue and participation stand out as pedagogical elements in this process.

Along these lines, the objective of this study was to discuss the theoretical-conceptual relationship between health promotion and critical education.

For this, the methodological procedure used was qualitative document analysis through content analysis techniques and procedures for interpreting a *corpus* of text (Bardin, 2010). This *corpus* was composed of seven sources of documents on health promotion, from 1986 to 2005.

### **The international health promotion movement from 1988 to 2005**

Six international conferences on health promotion were held subsequent to the First International Conference on Health Promotion, with the aim of expanding the discussions and their theoretical-practical development and implications for public policies over the coming years. These deserve to be mentioned because they contributed towards the conceptual development and articulation of health promotion proposals on the political agendas of heads of state and administrators at different levels of power around the world.

Although these documents (the Charters and Declarations sponsored by the World Health Organization and the Pan-American Health Organization) do not have the force of law, their publication as protocols of intentions among countries and multilateral bodies of the United Nations (Rabello, 2010) reaffirms what has been said for a long time regarding the role of disease as a source of inequality and an obstacle to human development and social justice. It can be stated that these documents express the meaning of health for individuals and groups, as a premise for improving their wellbeing. They seek to affirm the inseparable nature of what makes human beings: the biological, subjective, symbolic and social factors. Even though advances can be pointed out, it is important to state that all these documents were created within a worldwide context of

globalization and expansion of neoliberal regimes that intensified from the 1980s onwards, the time during which discourse on health promotion marked international healthcare thinking, especially among developed countries.

Our objective here was not to discuss the globalization process and its effects on society in general. Nevertheless, it cannot be forgotten that its course results from contemporary liberalism, and its consequences are felt in particular ways by different governments and people, thereby configuring a context of health promotion.

Globalization has been defined as a multifaceted worldwide phenomenon and has transformed the dimensions of economic, social, political, religious, juridical and cultural life within international, national and local contexts. Today, it is accepted that it is associated with economic-financial, migratory, communicational and cultural factors that are represented within worldwide scenarios.

However, many authors (Canclini, 2003; Fiori, 1998) have signaled that this process is not global in the sense of being a redistributive phenomenon and is not inclusive. Nor does it promote transfers of investments, power, resources, jobs or better quality of life from rich countries to developing countries. It is a vision for which an expanded spectrum of knowledge and comprehension regarding the effects of this integration movement on and for individuals' health is required.

The Second International Conference on Health Promotion, held in Australia in 1988, returned to the discussion on the official documents. At this conference, the Adelaide Declaration was drafted, in which the central theme was advocacy of healthy public policies and a commitment towards equality of access to goods and services that exist in different societies, so as to make it possible for everyone to improve their living and health conditions (WHO, 1988).

Healthy public policies include reaffirmation of the need to go beyond healthcare and the importance of the notion of intersectoral action. Another recommendation relates to community action and the role of formal education, in the sense of redirecting curricula towards placing value on creation of healthy environments and developing competency for knowing how to deal with this field. Although this is unknown, it becomes necessary for health promotion to succeed in complex societies (Lopes, 2008).

Despite the importance of this topic, many questions remain as challenges to be incorporated in the field of health promotion, including the following: How can intersectoral action be achieved if relationships are governed by fragmented rationality and hierarchical power relationships? How can the key players be identified and thus mediate in formulation of healthy public policies involving different sectors and levels of power? How can education be thought out in the context of intersectoral action, for it to have an impact on the population's health?

The official document from the Third International Conference on Health Promotion, held in Sweden in 1991 on the topic of environments favoring health, was the Sundsvall Declaration. The proposal drew the world's attention to the topic of the environment, in its physical, natural, social, economic, political and cultural dimensions, and to the consequences of its degradation for the health of populations. It recognized that societies have an important role in preserving, sustaining and creating places that favor and promote health, through the understanding that environments and health are interdependent and inseparable for human development and the quality of life of peoples and nations (WHO, 1991).

This conference retrieved strengthening of community action as one of the proposals for action that could also be developed for promoting environments favoring health. It reinforced the educational dimension through making it clear that there is a need to capacitate and recognize knowledge, especially among women, so that they can acquire power and control over their health and the environment through education and greater participation in decision-making processes.

The fourth event was held in Colombia in 1992. In reality, it is known as the First International Conference on Health Promotion in Latin America. Its final document was the Santa Fé de Bogotá Declaration, which recorded discussions on this topic within the context of Latin American developing countries. In addition, it denounced the situations of inequality, social injustice and

health injustice that characterize most of these countries and pointed out the need to place the precepts of health promotion with the context of their specific realities.

Despite the advances, the debate remained marked by tensions regarding what health promotion meant and what the real possibilities for a health promotion model were, given that the realities were so different from the situation of developed countries. Like in the other conferences, education was acclaimed as one of the strategies for diminishing social injustice within healthcare. In particular, it was emphasized that information and knowledge are tools that allow individuals and groups to participate and change to healthy lifestyles (WHO, 1992). In the light of such affirmations, it therefore has to be asked what educational concepts might contribute towards health promotion, given the realities in Brazil.

Another document of note is the Jakarta Declaration: New protagonists for a new era: guiding health promotion in the 21<sup>st</sup> century (Brazil, 2002; World Health Organization, WHO, 1997). This document represents the views of the 4<sup>th</sup> International Conference on Health Promotion, which was held in the capital of Indonesia in 1997. Its recommendations point in two essential directions towards successful health promotion.

The first recommendation reiterated the importance of working in an interlinked manner on the five fields of health promotion action sanctioned in Ottawa, rather than with a fragmented focus through using separate strategies. The second recommendation was in relation to health determinants. These were covered in a broad and nonspecific manner, in relation to what they represented within the scenario of globalized societies and how they could contribute effectively towards promoting social equality and health for all. This discussion has been deepened within the international and national spheres through critiques and adherence regarding its implications and how health promotion can be guided towards intervening in the social determinants of health.

Lastly, the conference reiterated the interest in education as a guide for health promotion strategies and actions, highlighting popular participation and empowerment, even though it did not explicitly mention the term: “to increase community capacity and give individuals the right to a voice” (WHO, 1997, p.14). Thus, a relationship was established with acquiring skills and knowledge for intervening in health determinants, which implies recognition of the importance of thinking out and developing educational processes within a critical perspective.

The 5<sup>th</sup> Global Conference on Health Promotion, which was held in Mexico City in 2000 (Brazil, 2002; WHO, 2000), compiled the international document known as the Mexico Declaration. Among the topics discussed, it was emphasized that health promotion should be considered to be a fundamental priority of local, regional, national and international public policies and programs, with the aim of healthcare equality. In addition, it signaled a commitment towards development of active participation by all sectors of civil society in implementing health promotion actions that might strengthen and expand partnerships within the healthcare field.

In the document from the 5<sup>th</sup> conference, social participation was shown at macro level in the spaces and shapes of linkage between the state and civil society. Nevertheless, the dimension of individuals’ participation as social subjects and protagonists of health promotion programs and policies that might take the reference point of decentralization of power and socialization of healthcare resources, strategies and actions was not recognized.

Through the individual dimension of participation, the aim is for subjects to gain emancipation and autonomy. For this, their social practices should be taken to be the basis and the interest in health promotion should be considered from these people’s point of view. These elements may create possibilities for constructing collective subjectivity that makes these people capable of identifying and fighting for improvements in their individual and collective healthcare.

The last of these documents was the Bangkok Charter for Health Promotion in the Globalized World (WHO, 2005), from the 6<sup>th</sup> International Conference on this topic, which was held in the Thai capital in August 2005. This document reaffirmed the definition of health promotion that had been produced for the Ottawa Charter and emphasized the recommendations of the previous

conferences. Discussions on the challenges of health promotion in a globalized world were highlighted such that healthcare was positioned as a central responsibility for everyone: governments, international organizations, the private sector, civil society, NGOs and communities. Regarding the recommendations for education, these were nonspecific and referred to civil society in general. The document also pointed towards community empowerment as the key to success (WHO, 2005), without adding new elements for accomplishing education from the perspective of empowerment, whether community-based or individual, within the field of health promotion.

In this brief description of the health promotion charters and declarations, it can be seen that education is present as a topic. The documents express different dimensions of education, which can be identified in the following, for example: in individual and community-based empowerment processes; in reinforcement of community action; in development of personal and social skills; as an option for healthy lifestyles; in popular participation; in capacitation of the population to make decisions favoring their health; and for participation in the policy decision-making process; among others.

### **Why is critical education within the field of health promotion necessary?**

In defining health promotion as “the process of capacitating individuals and groups to act towards improving their quality of life and health, including greater participation in controlling this process” (WHO, 1986), the Ottawa document emphasizes the importance of education within this field, since it takes the view that health is a lifelong resource and not an objective to be attained only when an individual is ill: “health is a positive concept emphasizing social and personal resources, as well as physical capabilities” (Kickbusch, 2003, p.384).

From this perspective, health is not a static objective but, rather, is processual. It refers to “degrees” of a developmental process that may be linked to loss, balance or gain of health over the course of life. In this respect, there is a need for critical awareness to be constructed, which also occurs in levels, i.e. individuals’ degrees of learning about social realities, about themselves and about the limits and possibilities for their own health. However, the state’s responsibilities towards enabling good quality of life for the population also form part of this viewpoint. This critical awareness, thus constructed, generates empowerment as a result from the participation process, with its consequent characteristic dialogue, especially when pedagogical actions relating to healthcare have the intention of contributing towards shaping identities and constructing critical subjects.

In the Ottawa Charter, education can be seen to be present, expressed in terms of the importance of active participation by the population as one of the essential elements for putting it into operation:

Health promotion is rooted in effective and concrete participation by the community in setting priorities, making decisions and drawing up and putting into operation planning strategies in order to attain better health levels. The driving force for this process comes from the real power of communities, and from the ownership and control that they have over their own efforts and destinies (Pan-American Health Organization, PAHO, 1996, p.369-70)

Throughout the work by the educator Paulo Freire, the importance of dialogue and participation were emphasized as pedagogical elements of the educational process: “dialogue consists of a horizontal relationship, and not vertical one, between the people involved and between the people in the relationship” (Gadotti et al., 2000, p. 103).

The pedagogical dialogue to which Freire referred has the aim of providing opportunities for participation by all the parties involved, and it implies that critical knowledge should exist, thus enabling praxis and action-reflection (also of critical nature), and thus, a situation of dialogue. Through dialogue and participation, the learned knowledge, the material content or knowable object is constructed, thereby generating new forms of knowledge based on experience. In this learning

process, everyone is a subject and the relationships between individuals and society are inseparable (Giroux, 1999; Freire, 1993).

Through conceptualizing health promotion as a capacitation process that allows people to acquire greater control over their health and environment, the implication from an educational point of view is that there is a need for changes in lifestyle and living conditions among the population and within society in a broad sense. This would imply not only that individuals should acquire knowledge, but also that they should construct and develop personal and social skills so that they can deal with the determinants of health and know how to select and make choices freely and thus favor both their health and their quality of life. This constitutes empowerment, both at individual and community level.

According to Giroux (1999, p.21) empowerment is “the capacity to think and act critically”.

From this perspective, empowerment involves an educational process that implies construction of critical awareness to overcome individual limitations and comprehend the limits imposed by society, so as to create possibilities for transforming social realities, as understood by Zimmerman (1990), apud Horochovski and Meirelles (2007).

Thus, the role of critical education is to contribute towards the mutual process of construction and shaping between individuals and society. For this reason, it can be said that the relationship between human potential and social potential implies educating people to be capable of thinking, acting and critically questioning and creatively intervening in social realities (Lopes, 2008; Giroux, 1999). These transformations can be seen most clearly in social movements.

In this respect, pedagogical dialogue requires an educational approach that makes it possible to implement transformational learning in which individuals and the community can construct new skills and attitudes in order to critically appropriate the benefits of health and its promotion, for the benefit of their daily lives and personal and collective development.

Contrary to this process, capacitation within traditional pedagogy is associated with transmission proposals: the idea that someone teaches other people to acquire knowledge in order to shape and adapt their lives, so as to meet the precepts of current education. Nonetheless, in the ideal of critical educational theory, the value of education is in shaping critical subjects through constructing knowledge and skills in order, in the case of health, to deal with the multiplicity and diversity of factors that exist within contemporary societies.

The possibility of constructing knowledge through critical shaping of what people know and their practices may contribute towards wholeness within humanity, within the perspective of better quality of life, which reinforces the need for critical education within the field of health promotion.

Health education from a critical perspective requires comprehension of the notion that education takes place in the form of a process, in which learning implies construction and not acquisition of knowledge. It signifies development of personal and social skills, and not adaptation or reproduction of behavior. However, it will only have value from a learning point of view if its meaning is adapted to the context of the sociocultural lives of the individuals or groups of individuals.

It thus becomes necessary to distinguish between “regulatory knowledge” and “emancipatory knowledge” (Santos, 2001, p.78-83). The first of these conceives of the second as the object and consequently does not recognize it as a subject; hence, regulatory knowledge is a principle placing order on things and on other people. On the other hand, with emancipatory knowledge, knowledge is recognition and implies progressing towards elevating other people from the condition of an object to the condition of a subject, such that this “recognitory knowledge” strengthens the educational process through “solidarity” (Santos, 2001, p.29-30), as configured in the proposals of critical educational theory.

Recognition of other people as subjects and placing value on their experiences should be present in all educational processes, including in relation to health education, because knowledge only has meaning when it generates creative and critical learning experiences that connect with the

expectations and lives of the “learning subjects” (Assmann, 1998), i.e. with what people think, feel and know.

It is important to state that changing the social health conditions and lifestyles of individuals and groups is not something that can be done simply through acquisition of knowledge or prescription of habits and conducts that will lead to living better and more healthily. Health, and consequently certain health habits, is rooted in the histories of civilizations (Rosen, 1994) and is associated with cultural and educational relationships, with economic, political and social structure development, and with living conditions that favor behavioral changes. It is not a matter of automating new healthy habits but, rather, of consciously constructing them through educational methods that favor this transformation, as proposed in critical educational theory (Lopes, 2008).

Therefore, proposing healthy lifestyle changes, especially for populations that have become marginalized and excluded from the process of social, economic and educational development, requires deepened reflection on what shapes their choices. The reasons why such choices are often outside of these individuals’ control and desires also need to be thought out (Lupton, 1999). Likewise, it also needs to be considered how such choices are related to what surrounds people’s lives, and to social and healthcare inequalities and other issues that are of essential interest for health promotion initiatives.

In the 1980s, the first criticisms of the theoretical and practical limits of approaches centered on changes to individual lifestyles emerged. Such approaches became known as the behaviorist tendency of health promotion.

There is no doubt that individualistic approaches provide a fertile field for expansion of neoliberal ideology within the healthcare field, thus reaffirming the premises of minimum social welfare and devolving from the state the responsibility for expansion of public policies in this field, as well as feeding a market that promotes consumption of necessities and stimulates all kinds of desires in which ideal health is craved.

In the name of personal autonomy, freedom and a healthier life, the responsibility for individuals’ control over their health has been transferred to the sphere of private life. Through this, the phenomenon of holding victims to blame has been provoked. This perspective excludes both the possibility of criticism regarding the crisis in present-day society, especially regarding health and health educational practice, and the possibility of questioning the power that has been delegated to people, i.e. what people really have for modifying power structures that multiply the control mechanisms that in a sophisticated manner regulate people’s capacity for individual and collective criticism.

The strategies derived from this approach have had a very small impact on the poorest groups within the population. Without access to material goods and basic social services that would help them through meeting possible needs and overcoming difficulties in adopting healthy practices, these people are unable to change their living conditions (Carvalho, 2004). On the other hand, groups that are more favored have also not been responding favorably to such approaches.

The scope of health promotion expanded when it became linked to approaches guided by critical educational theory, which has the objective of reestablishing the emancipatory critical potential of education. Despite the specific nature of the healthcare field, the links between education knowledge and health knowledge are undeniable, since “every healthcare action is an educational action, which implies that education should be included in health promotion” (Lopes, 2008, p.36).

Considering that health promotion has the aim of enabling transformatory praxis of health realities (WHO, 1986), it can be stated that in its practical-conceptual proposals, there is a strong pedagogical characteristic. Therefore, thinking and acting within the field of health promotion from the perspective of critical education involves recognition of scientific and popular knowledge. In the case of the latter, it cannot be thought about without taking into consideration an enormous range of issues such as: values, choices, desires, inclinations, necessities, singularities, power and conflicts at



individual and collective levels that may either be incorporated or discarded by individuals over the course of the process of learning and constructing knowledge about their health and environment.

## **Final remarks**

Naive readings of health promotion proposals or uncritical approaches towards them may induce readers and/or healthcare professionals to imagine that the health education process is simple.

It has to be borne in mind that two complex fields (education and health) are involved. It is not enough to reproduce technical knowledge or adopt vertical practices that aim to pass on or transmit readymade finished knowledge about health and quality of life. Such knowledge will not be incorporated without resistance or conflicts, or without cultural, personal and/or collective subjective views that are particular to experiences of disease or of feeling healthy.

Education is difficult to define, given the multiple meanings that it now carries. Within the traditional perspective, the concerns always related to transmitting knowledge and individuals' assimilation of values and ways of acting, so that they would develop institutionally consolidated competencies and skills. Thus, human adaptation was governed by rationale centered on standards and patterns that molded individuals' and groups' ways of acting and thinking, in order to meet the purposes of a given society. Such behavior is present in the day-to-day routine of healthcare services.

Nonetheless, emancipatory and liberating ideals have always been present within formal and informal education throughout the history of pedagogy, thereby signifying resistance to and innovation against processes of cultural domination (Giroux, 1999; Freire, 1993). Such thinking gives rise to the possibility of seeking critical theories.

From this perspective, education is not neutral but, rather, a social practice permeated with intentions, subjective views and purposes. It is a human activity that is constructed historically, thus constituting a sociocultural ethos and a way of being and living, just as health is too. Health is not just absence of disease, as argued in the preceding discussion.

Starting from this line of argument, health promotion education should be grounded in conceptions of critical education for capacitating individuals and communities, in which the aim of the training is not just for them to memorize concepts and instrumental knowledge about health but, rather, for them to develop skills and competencies that allow them to know how to access, decode, manage and, if necessary, criticize information and knowledge about their health and the environment.

Thinking out an educational proposal from the perspective of health promotion requires recognition of at least the following propositions:

- The field of education is situated such that it undergoes interactions and influences from other fields;
- Education consists of a set of formal and informal processes that may or may not be intentional and may or may not be systematized, which contribute towards people's development, humanization and social inclusion;
- Education is understood as a process that involves critical reflection, and therefore it recognizes that its subjects exist within sociocultural and historical contexts, and that there are individual and collective differences among those involved: healthcare teams, service users and people in their surrounds. This recognition implies knowing how these parties interfere with, act on and might contribute towards the learning processes.

From this perspective, critical educational theory becomes necessary for meeting the requirements within the field of health promotion, because it acts to shape the subjects' awareness, by mediating between them and their social realities, in order to achieve a personal and collective transformation. In summary, it can be concluded that, for the proposals contained in these documents to take concrete form, contributions from critical education are necessary and fundamental for promoting health.

## Collaborators

Rosane Carvalho Lopes was responsible for writing the text and Florence Romijn Tocantins was responsible for supervising and reviewing the text.

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