interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Debates
The National Policy of Popular Education in Health

The National Policy of Popular Education in Health in debate: (re) knowing knowledge and struggles for the production of Collective Health

A Política Nacional de Educação Popular em Saúde em debate: (re) conhecendo saberes e lutas para a produção da Saúde Coletiva (resumo: p. 15)

La Política Nacional de Educación Popular en Salud en debate: (re) conociendo saberes y luchas para la producción de la Salud Colectiva (resumen: p. 15)

José Ivo dos Santos Pedrosa[(a)]
<jivo@ufpi.edu.br>

[(a)] Curso de Medicina, Universidade Federal do Delta do Parnaíba, *campus* Ministro Reis Velloso. Avenida São Sebastião, 2819, Bairro N. S. Fátima. Parnaíba, PI, Brasil. 64202-020.

Reflections on Popular Education and Health (EPS) as a field of knowledge, subject action and public policy in the Brazilian National Health System (SUS) in Brazil. Based on the process of institutionalization of EPS in the Ministry of Health, viability conditions of the National Policy for Popular Education in Health (PNEP-SUS) are pointed out, formulated in dialogue with popular movements, based on two questions: What are the consequences of this process in the construction of health policies? What is the viability of PNEP-SUS in the current context? The debate emerges in the dialogue of this process with social participation, pedagogical conception of EPS, dialogues of knowledge and production of knowledge that permeate the relationship between social movements, SUS management and PNEPS-SUS.

Keywords: Health policies. Popular participation. Popular education and health.

Pedrosa JIS. The National Policy of Popular Education in Health in debate: (re) knowing knowledge and struggles for the production of Collective Health. Interface (Botucatu). 2021; 25: e200190
https://doi.org/10.1590/Interface.200190

Introduction

The starting point of this debate is the PNEPS-SUS established by Ordinance No. 2,761 of November 19th, 2013[1] of the Ministry of Health, whose essential theoretical and methodological principles are as follows: dialog, kindness, problematization, shared construction of knowledge, emancipation, and commitment to the construction of the Popular Democratic Project.

However, the starting point is also one of the arrival points of the historical journey of a movement that, around the epistemological and pedagogical foundation of Paulo Freire, is bringing together, in Brazil and in some Latin American countries, popular movements, traditional communities, researchers, health workers, professors and students, and social movements referred to as Movements of Popular Education in Health (MEPS), which act on the political intentionality of emancipating themselves from oppression using pedagogies that constitute subjects with a capacity produce sense for their lives.

The discussion has as historical marks a number of events that serve as the basis for the reflections elicited. The first is the institutionalization of the fundamental principles driving MEPS actions as organizational guidelines of a technical coordination in the structure of the Brazilian Ministry of Health; the second, related to the first, is when the popular movements become representatives in the shared construction of a public policy, the PNEPS-SUS.

In the current political moment in Brazil, a dismantling process can be perceived of the SUS as idealized by the Brazilian Sanitary Reform Movement with organizational changes in the structure and administration of public governmental institutions, such as the Ministry of Health, justified and subordinated to fiscal adjustments, interrogating two actions until then proposed and established in policies, around two triggering questions: What are the consequences of the institutionalization of Popular Education and Health (PEH) in the Ministry of Health? What is the viability of the PNEP-SUS in the current context?

These questions organize the text in two items in which elements supporting the debate were identified, so that these and other concerning questions can lead to reflections toward new trails and resignifications of our journey from the perspective of building the future.

What are the consequences of institutionalizing the PEH in the health policies?

Behind this question, we find the most general issue about the effects of libertarian impulses emanated by society, established in governmental institutions and organizations by the strength and desire of the social movements.

To understand the trajectory of PEH, thoughts and practices present in the MEPS and governmental institutional actions, it is necessary to establish popular education as a pedagogical and political movement in the 1960s, when Brazil had the two following perspectives: recognizing popular forces and strengthening the fragile incipient democracy, building a democratic and popular development project; or surrendering to the expansionist and monopolist capitalism of the time. The second path was chosen and, in 1964, the Military Dictatorship was established in the country.

Within the context of the populist liberal regime (pre-dictatorship), popular education emerges containing as foundations Paulo Freire's[2] concepts of problematization, emancipation, limit-situations, subjects of knowledge, dialog, and sharing in the construction of the unprecedented feasible in the perspective of a critical pedagogy that taught to read and write and made people aware as subjects in the world at the same time. His work entitled "Pedagogy of the Oppressed" brings essential elements to the understanding of phenomena permanently present in daily life that are naturalized and conceived as immutable, causing a collective paralyzation and an individual lack of knowledge of the existing powers within each human being and in different groups to which they join.

In this scenario of political disputes and struggles, the popular educational principles recommended by Freire[3] "get rid" of the perspective focused only on a pedagogy aiming at teaching to read and write and open themselves to the formation of subjects together with unions, professional and neighborhood associations, cultural centers, and centers of studies and press. In popular neighborhoods, societies of neighborhood friends and associations of residents were recovered, in addition to movements for day-care facilities, health, housing, transportation, legalization of clandestine subdivisions, education, basic sanitation, and specific demands[4]. Emblematic examples are the Popular Health Movement (MOPS), the Cost of Living Movement, and the Health Movement of the East Side of São Paulo, among others.

These movements aligned with more progressive segments of that time developed projects in which the knowledge of experiences and the will of those involved in constructing other forms of reading the world were considered, now from the perspective of those who since then only saw themselves as dominated.

PEH arises in this period mainly in small rural communities and urban outskirts, adding university students and professors by means of extension projects of the Departments of Preventive and Community Medicine with the support of the progressive wing of the Catholic Church known as Liberation Theology, characterized as the recovery of popular knowledge and practices in the ways of understanding and treating diseases and promoting health[5,6].

During the Military Dictatorship, these political spaces and the theoretical and methodological concepts of Freirian pedagogy survived resisting in small and isolated movements but always clustering people around the fight for better living conditions so that, with the re-democratization in the late 1980s, PEH was already characterized as an organized network movement, adding militants of the social movements, professors, students, researchers, and health workers mainly in primary care and mental health. It promotes meetings systematically to exchange experiences, train leaders, and develop popular and traditional health practices, even using new communication technologies, such as the list of the Popular Education in Health Network (RedePop) on the Internet.

In the VI Brazilian Congress on Collective Health in 2000 in Salvador, Bahia, a PEH Work Group was constituted in the Brazilian Association of Collective Health (Abrasco) through a workshop promoted by RedePop.

In 2002, in the X RedePop Meeting, a document was created and sent to the presidential candidate Luís Inácio Lula da Silva, in which the Network, as a social collective, proposed and demanded greater institutional participation in the SUS.

In 2003, the Transition Commission of the elected President proposed changes in the Ministry of Health structure, creating the Secretariat of Labor Management and Education in Health (SGTES) and the Secretariat of Strategic and Participatory Management (SEGEP). Popular Education in Health starts in the SGTES as the General Coordination of Popular Actions of Education in Health (CGAPES) and, in 2005, changes to the SEGEP as the General Coordination of Popular Education in Health and Social Mobilization (CEPSMS).

In this trajectory, the coordination of the MS with the MEPS is highlighted as institutional support to their organizations and promotion of meetings and conversation circles to reflect about their contribution to the strengthening of social participation in the SUS, the pedagogy present in the educational practices and knowledge production, i.e., understanding the PEH movements of the MS to know their consequences in the SUS, the PNEPS-SUS, and Brazilian society.

The initial action of the CGAPED was the partnership with RedePop to map, articulate, and mobilize the organization of the popular movements. A process that, using research methodologies/participatory action, enabled the identification and registration of nearly 800 movements (in many cases with little visibility and organization) which identified themselves as popular movements involved in PEH practices to mobilize and provide care actions for health and disease problems of the population.

The National Articulation of Movements and Practices of Popular Education and Health (Aneps), permanent forums of popular education in states and cities, listening spaces, exchange of experiences, training of social agents for the management of public policies, popular mobilization, organization and communication among the movements were the result from the mobilization and organization of state meetings[7].

In December 2003, the I National Meeting of the Aneps took place with participants of each Brazilian state, in which the proposals were systematized in seven large axes[8]:

a) Reaffirmation of the principles and guidelines of the SUS and assurance of its implementation;

b) Strengthening of social control and popular participation for effective implementation and evaluation of participatory health management;

c) The perspective of Popular Education in Health as an instrument of services management;

d) Construction of a popular education policy together with training centers, schools, and universities;

e) Support and strengthening of the popular fights in benefit of health;

f) Coordination of the fight for health with the social fights;

g) Ways of constructing and presenting intervention proposals.

In December 2008, the Aneps held the I National Meeting that gathered nearly 600 people, reflecting on the directions of the movement based on themes already pointed out in the first meeting, i.e., the relation between popular education and the management spaces, communication with other sectors and movements; popular participation and social control in health; training processes; and permanent education with the comprehensive and traditional practices of health care.

From March 9th to 11th, 2007, the III National Meeting of Popular Education and Health in São Carlos-SP, promoted by RedePop, had as its central theme "Knowledge and practices for health and social justice". The discussions were organized in the five axes: planning, methodology and evaluation of the Popular Education and Health actions in the dialog with popular knowledge and cultures; popular education in the work processes and health training; social control and popular participation; dimensions of health care in the popular practices; and research processes in Popular Education and Health, as well as processes of socialization and communication of scientific and technological knowledge.

Based on the experiences of university extension and the development of student protagonism, such as the Experience/Internship in the Reality of the SUS (VER-SUS) and the Experience/Internship in the Reality of Popular Movements (VerPop-SUS), the National Articulation of Popular Extensions in Health (AnePop) is organized, which performs an important role in the process of education, service, and community integration, an essential axis guiding the National Curriculum Guidelines of the Medicine Course[9], in accordance with the collectives of Popular Education and Health.

These and other events based on the PEH institutionalized foundation, i.e., the Coordinations of Popular Education of the MS (SGTES and SGEP), contributed to the leading role in the construction of future Popular Education in Health practices as a political movement, organized in social collectives, promoting the constitution of their subjects and defining their spaces in the SUS, the academy, and society.

Although referenced by the same ethical, political, and conceptual PEH principals, we observe that the Aneps brings more explicitly the political dimensions of social participation in the SUS management and practices, that the AnePop brings education, service, and community integration, and that RedePop is concerned about the critical evaluation of training processes, with ways of producing knowledge consistent with PEH principles, and with the dialog with other knowledge and cultures. What are the meeting points on this journey?

The effects and results of the PNEP-SUS journey are problematized in the dialog with the constituent principles of politics.

Regarding the popular democratic political project and in view of our historical democratic inexperience, what is the meaning of democracy and of participatory democracy experienced by organized collectives? What is the meaning of the organization for its components and its relationships with other social movements and with the public policies? What is the relationship of the collectives with the governmental structures?

The democratic construction of a political project is based on the effective participation of individuals, groups, and organizations in formulating problems, deliberating ways of coping and managing actions, raising the following question:

Has this movement of institutionalized EPS in the MS influenced and qualified the participatory processes and led to the system management changes?

In the SGTES, one of the PEH functions was to participate in the execution of a national project to train health counselors for the effective exercise of social control. In the SGEP, the purpose was to implement participatory management councils in each SUS unit, raising new questions: What is the relationship of the emerging collectives with the health councils? What conception of social participation made sense for the popular movements? What are the channels for participation? How were the PEH principles present or not present in the participatory processes?

For Melo and Possa[10]:

> The concept of participation as a practical category aims at attributing meaning to the collective action and political practice of the actors. In Brazil, it is related to the orientation of the actors' actions towards the emancipation ideal of the working classes. In this case, participation has an objective to be attained, in overcoming inequality, integrating redistributive policies, rights, and the access to the public services... (p. 397)

Concerning social participation, institutionalized spaces were broadened, such as health councils, other policy management councils, and specific sectors added to the administrative bureaucracy like Secretariats of Racial and Women Integration.

The point is to know how the PEH movements occupied these spaces. Brazilian democracy, even conceived as representative, provided the vocalization of the needs of excluded social groups and the visibility of those who sought to affirm their social identities, such as black-skinned individuals, LGBTs, people from the countryside, from the forest, on the streets, and gypsies.

How has PEH worked on this new situation, different from political and cultural contexts in the 1960s and 1970s, before the advance of neoliberal capital that at the same time invades and captures the classic relationship between capital and work based on expropriation and accumulation, shifting the discussion to the subjects' position in the sphere of consumption and not production?

It is possible that practices, even if based on critical thinking about determinants of oppressive situations, are captured by the logic of non-critical pragmatism, in which those involved do not feel subjects with the capacity to build and be committed to the desired future.

Such questioning makes one think about which pedagogy guides educational practices developed in a plural manner with several movements in all the states of the country. Studying popular education and social movements in Latin America, Carrillo[11] problematizes these practices, considering pedagogy as the process that changes educational practices into knowledge or pedagogical theories providing sustainability and qualifying them as popular education practices.

The same author summarizes four moments that compose the historicity of popular education in Latin America: a) Paulo Freire and awareness-raising literacy; b) the dialectical methodology and participatory techniques of popular education; c) the reunion of pedagogical with cultural dialog, and d) the pedagogical emergencies present in the current practices.

The leading role of the articulated collectives demanded training processes in all the Brazilian regions, bringing together subjects and creating innovative and participatory methodologies so that in the practices developed, Freirian theory, participatory techniques, and intercultural dialog were present in the pedagogical emergencies pointed out in the health policies as equality, participation in social control and management and integrality in care.

Did the PHE institutionalization trajectory promote dialog between popular knowledge and scientific technicians for comprehensive care? How has knowledge production and the training processes of conscious, critical, active, and creative subjects been for the SUS?

Such questions about care are based on the National Policy on Integrative and Complementary Practices (PICS)[12], in which the popular health practices followed a two-way path: at the same time, they gained more visibility, and in some experiences, were incorporated into the SUS services predominantly in Basic Health Units (BHUs) within the scope of the Family Health Strategy, mainly through popular herbal medicine; popular caregivers have adopted practices adapted or inspired by other cultures and other sources, such as reiki therapy, auriculotherapy, massage therapy, meditation, indigenous and traditional medicine practices, among others.

This situation puts the popular care practices in the health work process currently experienced in the SUS. We are driven by the desire to universalize comprehensive health care, but how much are these practices present in the definition of the care actions? The limits between comprehensive practices and alternative practices are very delicate and in the current context of the health sector in Brazil, we ask: Which the tendencies of these limits became explicit by naming popular practices as alternatives, external to the health system, offered to a population "with no use"[(b)] for the objectives of the ultra-neoliberal capitalism we experience today?

The theme of the health popular practices recalls an essential question in PEH concerning dialog and shared knowledge construction. A theme of such depth that goes from politics to actions experienced in a dialectical praxis perspective, bringing to debate the meaning of autonomy of the communities/cultures in their processes of health production and State duty, guided by technical, scientific, and bureaucratic rationalities.

The relationship between the academy and popular knowledge in a certain way has occurred, although it presents more characteristics of a monologue of movements that are occupying academic spaces in extension and research projects. However, they are not enough for a dialog established in the shared process of syntheses between different pieces of knowledge in constructing another rationality based on the singularities of each culture and knowledge. We occupy the universities with focal projects and few postgraduate training processes, but we still do not have presence in graduate and technical training of health professionals, and we have limited visibility as scientific production.

(b) This was the expression used by Federal Congresswoman Jandira Fegalli in her speech given at the XVI National Health Conference, held in Brasília in 2019, to designate the social groups which, from the classical Marxist perspective, referred to the lumpenproletariat.

What is the place of PEH in the Brazilian scientific production when the current government proposes classification parameters based on criteria that are distant from the contribution of knowledge to people's living well? Therefore, the Abrasco[13] asserts the following in an Open Letter:

> Concentrating the publication of the Brazilian scientific production in English-language journals, dominant in the databases considered in the proposed Qualis Journal, restricts access to this production to specialized readers. Thus, it limits the journals' role in disseminating updated scientific knowledge, indispensable to support training at the various levels and modalities of Postgraduate studies, as well as the formulation and implementation of national public policies. (p. 1)

The Abrasco's PEH work group has mobilized the scientific production and the systematization of experiences in the area, promoting the publication of books, scientific articles, meetings, and seminars that are very significant for everyone. Within this context, how are we defined in the academic spaces that we occupy?

In a sense, a future is pointed out that begins to be outlined with the Freirian question: Why must human knowledge considered science follow certain parameters? Could it not be different? And, walking along this path, we will inevitable find the sphinx asking the following question: Who serves science and technology developed by the scientific production centers, such as the universities? Moreover, as in Oedipus' reply, it is possible to say that, in the first moment, scientific production initiates future scientists through their integration in research studies in development within universities; in the second moment, the initiated reproduce learned knowledge models already inserted in the productive process; in the third moment, technical and scientific knowledge is commercialized under the mediation of development agencies, research funders, and the publishing sector.

Thus, the reflection expands on pieces of knowledge that go beyond the domains of science that, in Brazil and countries that suffered colonization processes, have their references in Northern Epistemology[14] and that predominate in the training of health professionals.

How to promote knowledge dialog if there is no recognition of other subjects as interlocutors and authors of a different thought about reality? PEH is recognized and validated as academic knowledge in interdisciplinary fields in courses of improvement, specialization, and some Collective Health, Family, and Education programs at the masters and doctoral levels.

Despite this, some questions remain regarding the affirmation of PEH as a scientific field in which critical thinking and transformative intervention in reality prevail. According to the current parameters, there are no descriptors for Popular Education in Health and no public notices, and in the journals where we publish, they have a low impact factor most of the times.

In this perspective, the challenge is to decolonize the production and reproduction process of dominant scientific knowledge, subordinating to the scientificity rules given by metrics in which the effects and impacts of research studies are not accounted for, e.g., on people's way of living.

How has PEH, which tensions this knowledge and its forms of production and applicability, led dialogs within the academy's peninsular spaces? In other words, how does PEH include itself in collective health as a core aggregator of popular knowledge and practices presenting singularities in their rationalities, action spaces, and subjects?

These questions become visible in the process of affirmation, recognition, and institutionalization of PEH and serve as a basis for the second question that organized this debate.

What are the viability conditions of the PNEP-SUS in the current context?

The EPS institutionalized in the MS, when articulating with the social movements, presented as an organizational strategy to remain established within the instituted, advancing in the institutionalization process[15] in a dispute scenario around the micro institutional powers at the same time that it sought visibility as a technical area of the MS structure, along with state and municipal levels of SUS management. Does the strength of the instituted in the organizations have such a weight and strength with the capacity to capture and materialize what the instituting part wanted?

The PNEP-SUS was part of the National Policy for Strategic and Participatory Management (ParticipaSUS) presented by the SUS Secretariat for Strategic and Participatory Management (SGPEP) of 2007[15] and was in line with the policies to promote equality. In the current organizational chart of the MS, this body was instinct.

However, the SUS management from 2003 to 2016 underwent changes that influenced its organizational structure and introduced innovative public policy formulation and management processes that resonated in the Brazilian states and cities. Some specific policies, such as the National Policy for Health Promotion (PNPS)[16] of 2006 and the National Policy for Humanization (PHN)[17] in the SUS, had in their structural framework Management Committees articulating various sectors of the MS and non-governmental and scientific organizations.

Regarding policy formulation, the organizational architecture was constituted by participation spaces with representations from the MS, and from civil society groups, giving rise to the Health Technical Committees of the Black-Skinned, LGBT, Countryside and Forest, Gypsy, and Homeless Populations, as well as that of Popular Education in Health.

One of these committees' duties was to contribute to the formulation of specific policies based on the demands presented by their representatives. Although there are no systematized research studies on the effect of the committee products, we have notes on the organization of their work and their representations. Some were more effective than others, they were spaces for negotiation and agreement, and their results are systematized in the Equality Promotion Policy of the SUS[18], which includes the following in its introduction:

> In the scope of the Ministry of Health, the Participatory Management Support Department of the Secretariat of Strategic and Participatory Management has a priority to support the organization of Technical Committees of Health Equality Promotion in states and cities. In the practice, the policies for health equality promotion create a set of actions and health services prioritized according to the severity of the disease, helping to achieve, in an equal and universal manner, the biggest challenge of the SUS, the guarantee of resolute, timely, and quality access to health actions and services. (p. 6)

The Committees' action is also linked to another innovation related to policy management, which was the creation of Integrated Support (AI) through the presence of professionals from the MS or contracted as consultants to work with state and municipal health secretariats to monitor and develop permanent education processes for the implementation of the policies. Most of the Brazilian states established Health Equality Promotion Committees in their State Health Secretariats during this period.

The Integrated Support for the Implementation of the ParticipaSUS Policy is defined as the political strategy of the SGEP in providing the construction of favorable scenarios, guiding implementation processes, building viability, and monitoring its development and implementation.

Thus, the supporter's work is defined according to the nature of the support demanded based on the ParticipaSUS axes, resulting in the promotion of events that make social participation visible and motivating, and the triggering of processes generating other processes (projects, programs, actions) with the capacity to intervene favorably towards the policy implementation.

It is therefore characterized as an eminently relational action because it translates to its interlocutors the possibilities pointed out in the SGEP policy by means of strategic actions, by offering information situating the interlocutor in the implementation process of ParticipaSUS, and as communicative, because its viability is built in a shared manner with the local actors, whose consistency is mediated by the context presented. In summary, it is a pedagogical intervention in the sense that it builds strategies aimed at the policy dimensions that will affect the organizations' structure and processes that make up the management of the SUS and in the movements of the political, governmental, and civil society actors.

Given these movements, in the dimension instituted in the organizations, the necessary reflection is based on the effects of these processes, that is, at the level of relationships between Committees and the Government (herein understood as the set of structural, political, procedural, and normative conditions constituting fundamental elements for the viability of a policy) and regarding the processes triggered by the integrated support. Therefore, the following question is raised: What are their effects? What is the pedagogy that guided the training of these supporters and their educational actions? Where and how did PEH participate in this process? Where and how were the Equality Promotion Committees implemented?

In the instituting dimension, that is, in the desires, demands, and organization level of the social movements in their uniqueness and in the processes that occur in the particularity of policy formulation, questions arise ranging from the representativeness of each social movement in the Committees to the deliberative role of these collectives to insert their demands/desires in the policy text and at the participation level.

In political terms, when talking about promoting health equality for excluded populations, we immediately add social groups and, ironically, we generalize them due to their singularities as blacks, LGBTs, homeless, gypsy Indians, from the countryside and forest, contributing to making vulnerability more visible in the world. However, in each social group, exclusion and its effects are specific. For example, the Black-Skinned Population Health Committee includes *quilombolas*, *terreiro* populations, and militants against racism.

This certainly brings us to a theme that has been returning to the philosophical and conceptual debate, as it concerns the multiple social and political identities emerging as effects of social exclusion. Multiple identities in transition are themes that demand new meanings, mainly in the educational practices with the popular movements.

How did the different expressions of inequalities dialog and produce intervention proposals that were included as political guidelines? By turning this question into a more general one, how did the internal democracy to each group occur, and how were consensus or dissents built?

The particular dimension in the PNEPS-SUS formulation process, approved by the National Health Council on 12/12/2012, is found in the holding of state, regional, and local forums as an initiative of the National Committee, including the following movements: Aneps, RedePop, AnePop, Abrasco, Landless Workers' Movement (MST), National Confederation of Agricultural Workers (Contag), MOPS, Movement for the Reintegration of People Affected by Hansen (Morhan), Peasant Women Movement (MMC), National Network of Afro-Brazilian Religions and Health (Renafro), Popular Movements Center (CMP), National Confederation of Community Health Agents, and Network of Traditional Midwives[19].

The Committee added social groups that, even based on the inequality situation, assert themselves in their singularities, which strengthens them as legitimate interlocutors of their group's needs. Discussions at state meetings demonstrated the possibility of producing consensus through dialog between differences, to the point of being able to build the PNEP-SUS text with its political principles and guidelines.

Provisional synthesis for more reflections and debates

Several questions raised are linked to problems on two levels. The first concerns the moment of policy implementation when the democratic context begins to be threatened and the PNEP-SUS is ignored: What is the power of the PEH practices developed in the movements to add supporters and act as resistance?

In the conception of what forms of political fight developed based on critical awareness raising were the active popular movements active? It was possible to formulate a public policy but, will it be possible to build a State to guarantee that the policy formulated becomes a reality in people's lives?

The non-feasibility of the PNEP-SUS in the current context seems a reality. This confirmation opens new reflections on the relationship between social subjects, movements, their representatives, and the government. On one side, how to live with and diffuse the institutional power considering that, as a public policy, it must be established so that the formulated policies can be expressed in the organizations and the SUS practices, and legitimated by the governments.

On the other hand, the representatives of the popular movements, interlocutors in their formulation, brought specific demands not always resulting from shared agendas, and, therefore, with a considerable probability that dialog turned into a dispute, a fragility that can be captured and used as a strategy to further divide the movements.

The second plan is in the nature of policies like the PNEPS-SUS, motivated by the population's desire to change their living conditions, different from policies formulated to face problems recognized as State demands.

As an expression of desire, these policies, which do not necessarily integrate the basic needs of production and reproduction of capitalism, are the first and main victims of the economic readjustments of public expenditure. At present, there is a reduction of the State and privatization of social rights, very similar to the situation described by Stuckler and Basu[20] in their book entitled "The Body Economic, Why Austerity Kills" in which the effects of policies to restrict the social benefits imposed by the crisis in European neoliberalism in the 1980s, increased mortality from suicide, and worsening of diseases such as tuberculosis, alcoholism, and chronic conditions.

This scenario generates a final question regarding the global crisis of the neoliberal model and the current ultra-neoliberal one, as follows: What feasible unprecedented could be built for the country with the contribution of PEH in the political and pedagogical dimensions that characterize it as an emancipator?

Finally, it is believed that these discussions will stimulate the VI National Meeting and I Latin American Meeting of Popular Education in Health, promoted by the PEH movements, having as the following as its main theme: Paths to strengthen democracy and emancipation, and to build living well.

Conflict of interest

The authors have no conflict of interest to declare

Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type (https://creativecommons.org/licenses/by/4.0/deed.en).

Editor: Antonio Pithon Cyrino
Associated editor: Pedro José Santos Carneiro Cruz
Translator: Helena Maria Scherlowski Leal David

Submitted on 04/10/20.
Approved on 07/27/20.

References

1. Brasil. Ministério da Saúde. Portaria nº 2.761, de 19 de Novembro de 2013. Institui a Política Nacional de Educação Popular em Saúde no âmbito do SUS (PNEPS-SUS). Brasília: Ministério da Saúde; 2013.
2. Freire P. Pedagogia do oprimido. 36a ed. São Paulo: Paz e Terra; 2003.
3. Freire P. Pedagogia da autonomia: saberes necessários à prática pedagógica. 58a ed. São Paulo: Paz e Terra; 2014.
4. Freire A. Organizações e movimentos populares e de trabalhadores na segunda metade dos anos 70 ou de um tempo quando não havia guias geniais dos povos [Internet]. São Paulo: Fundação Perseu Abramo; 2006 [citado 24 Jun 2020]. Disponível em: https://fpabramo.org.br/2006/04/20/organizacoes-e-movimentos-populares-e-de-trabalhadores-na-segunda-metade-dos-anos-70-ou-de-um-tempo-quando-nao-havia-guias-geniais-dos-povos/
5. Vasconcelos EM. Redefinindo as práticas de saúde a partir de experiências de educação popular nos serviços de saúde. Interface (Botucatu). 2001; 5(8):121-6.
6. Stotz EN. Os desafios para o SUS e a educação popular: uma análise baseada na dialética da satisfação das necessidades de saúde. Brasília: Ministério da Saúde; 2004. p. 284-99. (VER-SUS Brasil: Cadernos de textos).
7. Pedrosa JI. Educação popular em saúde e gestão participativa no Sistema Único de Saúde. Rev APS. 2008; 11(3):303-13.
8. Articulação Nacional de Educação Popular e Saúde - ANEPS. O caminho das águas: relatório do I Encontro Nacional da ANEPS. Passo Fundo: ANEPS; 2005.

9. Brasil. Ministério da Educação. Resolução CNE/CES nº 3, de 20 de Junho de 2014. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina e dá outras providências. Diário Oficial da União. 23 Jun 2014.
10. Melo RC, Possa LB. A democracia no SUS, como estamos? Um debate sobre participação social a partir da literatura recente. Saude Redes. 2016; 2(4):392-408.
11. Carrilo AT. Educación popular y movimentos sociales em América Latina. Buenos Aires: Biblos; 2016.
12. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Práticas Integrativas e Complementares no SUS - PNPIC. Brasília: Ministério da Saúde; 2006.
13. Associação Brasileira de Saúde Coletiva - ABRASCO. Critérios para classificação das revistas: apreciação da proposta de Qualis Periódico Referência [Internet]. Rio de Janeiro: ABRASCO; 2019 [citado 21 Set 2019]. Disponível em: https://www.abrasco.org.br/site/outras-noticias/notas-oficiais-abrasco/apreciacao-da-proposta-de-qualis-periodico-referencia/42328/
14. Santos BS, Meneses MP. Epistemologias do Sul. Coimbra: Almedina; 2009.
15. L`Abbate S, Mourão LC, Pezzato LM. Análise institucional & saúde coletiva. São Paulo: Hucitec; 2013.
16. Brasil. Ministério da Saúde. Politica Nacional de Gestão Estratégica e Participativa no SUS [Internet]. Brasília: Ministério da Saúde; 2007 [citado 31 Set 2019]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/participasus_aprovado_2007.pdf
17. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. 3a ed. Brasília: Ministério da Saúde; 2010.
18. Brasil. Ministério da Saúde. Política Nacional de Humanização. Brasília: Ministério da Saúde; 2013.
19. Brasil. Ministério da Saúde. Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Políticas de promoção da equidade em saúde. Brasília: Ministério da Saúde; 2013.
20. Pedrosa JI. La participación popular en la construcción del espacio público para la formulación de políticas: un camino de empoderamiento. Rev Monit Estrategico (Medellin). 2013; (3):66-73.
21. Stuckler DS, Basu S. A economia desumana: porque mata a austeridade. Lisboa: Editorial Bizâncio; 2014.

Este texto se constitui em reflexões sobre Educação Popular em Saúde (EPS) como campo de conhecimento, ação de sujeitos e política pública no Sistema Único de Saúde (SUS) no Brasil. Com base no processo de institucionalização da EPS no Ministério da Saúde são apontadas condições de viabilidade da Política Nacional de Educação Popular em Saúde (PNEP-SUS), formulada em interlocução com movimentos populares, a partir de duas questões: Quais os reflexos desse processo na construção de políticas de saúde? Qual a viabilidade da PNEP-SUS no contexto atual? O debate emerge no diálogo desse processo com a participação social, concepção pedagógica da EPS, diálogos de saberes e produção de conhecimentos que permeiam a relação entre movimentos sociais, gestão do SUS e a PNEPS-SUS.

Palavras-chave: Políticas de saúde. Participação popular. Educação popular em saúde.

Este artículo propone reflexiones sobre Educación Popular y Salud (EPS) como campo de conocimiento, acción de sujetos y política pública en el Sistema Brasileño de Salud (SUS) en Brasil. Con base en el proceso de institucionalización de la EPS en el Ministerio de la Salud se señalan condiciones de viabilidad de la Política Nacional de Educación Popular en Salud (PNEP-SUS), formulada en interlocución con movimientos populares a partir de dos preguntas: ¿Cuáles son los reflejos de ese proceso en la construcción de políticas de salud? ¿Cuál es la viabilidad de la PNEP-SUS en el contexto actual? El debate surge en el diálogo de ese proceso con la participación social, concepción pedagógica de la EPS, diálogos de saberes y producción de conocimientos que atraviesan la relación entre movimientos sociales, gestión del SUS y la PNEPS-SUS.

Palabras clave: Políticas de salud. Participación popular. Educación popular y salud.