DOI: 10.1590/1413-81232023288.05802023EN

ARTICLE

Health promotion competencies in the multidisciplinary residency: capacity for change and health advocacy

Jéssica Pinheiro Carnaúba (https://orcid.org/0000-0002-3571-6194) [1]
Marcelo José Monteiro Ferreira (https://orcid.org/0000-0001-5187-4195) [1]

Abstract *Health Promotion consists of individual and group strategies to achieve equity and reduce risks related to the Social Determinants of Health. This study aims to analyze the Capacity for Change and Health Advocacy domains of the CompHP in the reality of a Multidisciplinary Residency Program in Family and Community Health. This qualitative exploratory research was conducted with twenty-one participants. Data were interpreted through Discourse Analysis under the lens of Depth Hermeneutics. In the capacity for change, we identified that promoting healthy lifestyles is insufficient to develop autonomous and emancipated individuals in the search for decent living conditions. Concerning health advocacy, residents guide clients on the importance of popular participation in spaces intended for social control in Primary Health Care.*

Key words *Empowerment, Health Promotion, Continuing Education, Competency-Based Education*

[1] Universidade Federal do Ceará. Av. da Universidade 2853, Benfica. 60020-181 Fortaleza CE Brasil.
marceloferreira@ufc.br

Introduction

Health Promotion (HP) consists of individual and group strategies to achieve equity, quality of life, and lower risks and vulnerabilities related to the Social Determinants of Health (SDH). To this end, it articulates actions with the Health Care Network (RAS) and social protection and involves existing policies and technologies. It also considers the subjects' autonomy and uniqueness in their territories related to their social, economic, political, and cultural context[1].

In Brazil, the Ministry of Health started a broad debate in 2005 to guide on the importance of incorporating HP into the daily practice of health services. This process resulted in elaborating the National Health Promotion Policy (PNPS)[2]. The institutionalization of this policy legitimized the State's commitment to promoting and qualifying HP actions, becoming part of the strategic agenda of managers and expanding the public policies' perspectives[1].

However, effectively incorporating the PNPS into the daily practices of the Unified Health System (SUS) also requires reorganizing the training of health professionals. The Family Health Strategy (ESF) has been identified as an essential alternative for implementing and qualifying HP actions. Among its potentialities is the shift of a paradigm from the perspective centered on the individual disease toward a conception of comprehensive care for the family's health. Thus, it favors care longitudinality without disregarding the impacts of health determinants and conditions on the health-disease binomial[3].

The Multidisciplinary Residency in Family and Community Health (RMSFC) stands out in the ESF context by promoting meaningful change and the development of professional competencies. The RMSFC aims to reconfigure practices oriented towards the SUS reality in an interprofessional action and develop competencies and attitudes centered on the health needs of populations[4,5].

The project titled "Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe" (CompHP)[6] was proposed to systematize and guide the incorporation of HP competencies into the reality of services. CompHP comprises nine domains: Health Advocacy, Possibility for Changes and Mediation Through Partnerships, Leadership, Communication, Diagnosis, Planning, Implementation, and Evaluation and Research. It also has a set of values and ethical principles that should underpin the actions and competencies to be developed in HP[7,8].

The authors point out that Health Promotion Competencies (HPC) models bring directly or indirectly the international consensus related to CompHP[9]. Moreover, studies indicate that Brazilian professional training models can benefit significantly from the CompHP proposal[8,10]. There is evidence of the importance of reorienting professional training towards HPC, emphasizing the CompHP reference as a guide for training health workers[11].

We highlight two main competencies proposed by CompHP. The first is the "capacity for change", which means enabling individuals and the community to build competencies that favor their health, besides using health promotion approaches that support empowerment, leadership, and equity and the construction of capacities for action in health promotion[12]. The second is "health advocacy", which focuses on claiming better health conditions and quality of life for individuals and communities[12]. Both competencies underlie the political-social axis related to the empowerment of individuals on decisions regarding their health and the search for more equitable public policies[12].

Professionals working in Primary Health Care (PHC) often reveal the HP concept restrictively and with difficulties in societal aspects to understand and actively participate in the health process and modify their surrounding environment. Data indicate that the concepts of empowerment, participation, and social control in HP actions are minimally mentioned by health professionals[13].

In this sense, new discussions regarding empowerment and community development in the context of HP involving Continuing Health Education Programs (EPS) are suggested. Furthermore, we recommend exploring professionals' knowledge and practice regarding their actions' effectiveness to contribute to the reflection and reconstruction of their practices[14].

In Ceará, Brazil, the RMSFC, coordinated by the School of Public Health of Ceará (ESP/CE), aims at training/qualifying different professional categories within the PHC as a residency. Work-mediated education prepares workers to operate in the reality of the SUS from a perspective of interprofessionality, intersectoriality, and comprehensiveness[15].

ESP/CE's RMSFC Program associates training with professional activity in the health service, oriented under the SUS principles and

guidelines and per local and regional needs and conditionalities. As a result, the RMSFC have already reached the potential for change, such as developing team accountability actions regarding care and resolving health problems[16,17].

Despite being an essential training and professional qualification center for Public Health in the Northeast, few studies address the development of Health Promotion Competencies (HPC) in professional training within the RMSFC of Ceará. These studies are even scarcer when focused on analyzing the Capacity for Change and Health Advocacy domains[18]. Given the above, the present study aims to analyze the Capacity for Change and Health Advocacy of the CompHP in the reality of an RMSFC.

Methods

This qualitative, exploratory study is based on the theoretical framework of the Core Health Promotion Competencies of the CompHP[7]. It was conducted from June to August 2019 and investigated the RMSFC program offered by ESP/CE.

Residents (R), Preceptors (P), and Tutors (T) participated in the study, totaling twenty-one participants. The professional category of the tutors consisted of a nurse and a physical educator, both Family Health experts. The Preceptors were trained according to the professional category of the residents: psychology, social assistance, nursing, physiotherapy, dentistry, and nutrition. Preceptors and tutors had at least two years of professional experience in residency, while residents were in their second training year.

Two municipalities were selected to conduct this research. Thus, the criterion adopted to choose the assigned settings was having resident professionals in their second training year (R2). Considering these factors, we selected Quixadá and Quixeramobim, both bordering municipalities located in the Central Hinterland of the state of Ceará.

As inclusion criteria for residents, preceptors, and tutors, we opted for professionals who were at least in their second work year regarding the RMSFC of ESP/CE and were in full professional practice when conducting fieldwork. Thus, the universe of research subjects counted on the participation of 21 individuals.

In Quixeramobim, data were collected with seven residents, four center preceptors, and one field preceptor. In Quixadá, data were collected with four residents, two center preceptors, and one field preceptor. Finally, two ESP/CE tutors completed the group of research participants.

Three techniques were adopted in this research to acquire empirical material. Initially, document analysis was conducted to gather evidence for the theoretical-conceptual foundation. In this process, we resorted to the analysis of the Pedagogical Political Project (PPP) and bibliographic materials used as a reference for training residents. Next, five Focus Groups (FG) were held to promote debate and exchange of experiences among study participants[19]. Finally, after identifying gaps in the corpus of the assembled text, four more semi-structured interviews were held, two with residents, one with a tutor, and another with a preceptor[20].

Moreover, the approximation with the study object was grounded on the authors' previous experiences, as both had been residents of the Multidisciplinary Family Health Program. However, during the research, they were no longer included in this formative process, and there were no links with the ESP/CE. We employed the Depth Hermeneutics (DH)[21] as a theoretical foundation to interpret the qualitative material, which was justified by the possibility of deepening the symbolic universe produced by the language of subjects included in a specific socio-historical context[21].

According to the DH, the first analysis phase consists of socio-historical analysis, which considers that symbolic formations are built in a typical social and historical context[21]. To this end, after the transcriptions, we thoroughly read the qualitative material to understand the statements at hand and relate them to social and historical contexts. This process was supported by a theoretical deepening vis-à-vis the documents and materials that underlie the formative process of this RMSFC.

Then, we proceed with the formal or discursive analysis, which addresses the complex symbolic formations that permeate the social fields from which something is enunciated or manifested[21]. In this sense, Discourse Analysis (DA) was adopted as an interpretation method to seek the meaning and the content of a text[22]. In this research, the DA was performed from the social and historical contexts that permeated the participants' statements, critically and aligned with the CompHP[7] and DH[21] theoretical-methodological framework. Finally, the study's stakeholders agreed that the statements arising from the transcripts would be processed collectively.

The interpretation/reinterpretation phase permeates the entire DH process through the synthesis and reconstruction of probable mean-

ings; that is, an explanatory interpretation of symbolic forms. In this sense, when using the DH framework, we interpret something that individuals have previously interpreted and (re) construct a new meaning that may be different from the one initially conferred[21].

The study was conducted under Resolution No. 510/2016 of the National Health Council linked to the Ministry of Health[23] and approved by the Research Ethics Committee (CEP) of the Federal University of Ceará, under Opinion No. 3.313.043.

Results and discussion

Capacity for change

In the domain related to the capacity for change in CompHP[7], our study identified the following competencies: carrying out actions that seek empowerment; promoting the development of communities, favoring popular participation and the development of capacities to produce actions in HP, and helping the development of individual competencies that contribute to improving health:

We saw the issue of empowerment and enlightenment a lot [...], making this empowerment not an obligation but that people can face their current needs (GF-R).

We always understand that residency allows us to leave those practices that are very focused on care and work with other individuals on the issue of shared responsibility. So, with the know-how, the know-how-to-be, we get a better line of awareness for the community, for them to understand that they are part of the process (E-P).

In light of the theoretical-methodological framework of Depth Hermeneutics, we can understand that discourse analysis occurs in an intrinsic relationship between the symbolic universe and concrete reality[21]. This conceptual basis was essential for us to analyze how dimensions in the field of meanings, such as empowerment and shared responsibility, are mediated and materialized in professional practices. Silva *et al.*[24] show the capacity for change identified from the participation of stakeholders in the HP actions performed amid the interlocution between meanings and practices, which evidenced a willingness to learn and generate autonomy and empowerment in the decisions of these individuals. In another research, the capacity for change was considered incipient and fragmented. However, the HP actions expanded the participants' access and empowerment[25].

Residents see the notion of empowerment as a way to stimulate the clients' autonomy regarding good decisions for their health. Also, the term "empower" can be understood as a way to sensitize people on decision-making to seek the resolution of concrete problems aligned with the health needs of individuals.

Regarding the capacity for change domain[7], empowerment is associated with promoting equity and developing public policies that collaborate with the population's health, helping to face the SDHs. In this understanding, HP cannot be based only on the idea that subjects can self-regulate and manage their health. Conditions related to food, healthy environments, and access to information exceed healthy lifestyle habits, requiring public policies and access to services that respond effectively to health needs[26].

The autonomy concept is rooted in the freedom culture, in which all human beings can choose and adopt ways of life. However, we should understand that, under the theoretical framework of DH, such choices are limited to the socio-historical context of inequalities designed in the capitalist society's core[21]. Thus, it becomes easier to understand that issues related to well-being transcend the health sector and depend on better living conditions. In this sense, HP conceptions are influenced by neoliberalism, in which the power to choose is taken as a justification to legitimize the insufficient state public policies[26]. Limiting HP to the concept of educating for acquiring healthy lifestyle habits reduces the superficiality of discussions about public policies that involve the health-disease process[26].

Involving the population is fundamental for developing autonomy. In this sense, performing educational activities encourages popular participation and community empowerment:

The issue of hand hygiene, garbage collection, we all show what it is. We make a dynamic and try to take it into their lives so that they acquire that knowledge and change something (E-R).

We always try to work with this aspect more creatively to secure better access for people (E-P).

Residents, preceptors, and tutors realize the importance of involving the population so that educational activities are really apprehended. To this end, they consider that these actions should be developed dynamically, playfully, and based on individual needs.

Ciência & Saúde Coletiva, 28(8):2227-2236, 2023

Health education favors self-care and individual and collective health management. It does not distance clients but links them to units[27].

Pedagogical practices can provide dialogue and debate, leading professionals and clients to build substantial autonomy. In this sense, using games and dynamics enables the involvement and awakening of the participants' emotions and experiences[28].

Thus, it is necessary to support individuals and communities in which they can be aware of their potential, emphasizing widespread knowledge and self-care. Thus, training people who develop autonomy over their ways of living is possible, which is the direction for HP actions[29]:

Because of the constant activities and the residency always preaches this health promotion issue, we always have that constant practice of activities, unlike the service professional who does it once, which are very one-off. We always look for the most interactive, dynamic way about what we want to convey (GF-R).

The reports show the use of dynamics and other strategies to facilitate the understanding and participation of clients to favor the acquisition and sharing of knowledge. Moreover, HP activities undertaken by residents are more frequent, contributing to the continuity of actions and expanding community participation.

As residents are not the professionals fully responsible for services in the ESF, they have more time to develop educational actions, which differs them from service professionals, who have a greater demand for care and meeting goals. Thus, the health education actions conducted in the residency are systematic, allowing their continuity and, consequently, the clients' acquisition of knowledge and more robust information.

Health education activities are essential as they help build knowledge and facilitate healthier decision-making by individuals. However, overcoming the superficial conception of individuals who only need to be educated is essential, instigating the development of an emancipatory autonomy, which leads individuals to reflect on their realities and seek better living conditions from more egalitarian public policies[29].

In the residency training process, it is necessary to make residents aware of the need to promote health education activities that can transcend teaching healthy lifestyle habits. Thus, actions are needed to promote reflection and criticality on citizenship and social participation to improve existing services and lead them to develop a critical awareness vis-à-vis their desires and life habits.

Health advocacy

The competencies in the Health Advocacy domain are related to using techniques to claim better health conditions; promoting engagement with influential people of the communities; deepening public opinion regarding health matters; requesting from the sectors responsible for developing public policies' actions that bring positive impacts; encourage communities to articulate to respond to their needs for HP actions[7]:

We always make them [clients] participate in health conferences because they have an active voice. We are constantly working on literacy at the conferences so they can say what they need (GF-P).

In the PSF we work, we have an active local Health Council, and we always say that it exists and that those who feel comfortable can attend these meetings. It has already happened to arrive at the post and not have a tensiometer or a device to check the blood glucose, and clients say that this post has nothing. We say to clients that they have a voice to look out for these things and change the health unit they belong to (E-R).

The Health Advocacy domain linked to the construction of user citizenship and popular participation was noticed in the discourses. In this sense, residents encourage clients' participation in the Local Health Councils (CLS) and health conferences as active voices to claim better conditions regarding health services[30], and by analyzing the understanding of health advocacy, they unveiled the term as protection of the SUS as a universal system, valuing equity and social justice. Moreover, the authors emphasize popular participation as an essential basis for making clients and professionals jointly responsible for the struggle for their rights.

Thus, from the discursive analysis conducted through the theoretical framework of Depth Hermeneutics, we can understand the relevance of the different social stakeholders in the formulation of discourses that seek to "overcome domination relationships"[21](p.76). By encouraging community participation in the CLS, residents fulfill the duty to promote knowledge of the actual role of health councils. Also, through the political axis in the RMSFC, clients are instigated to claim better conditions of care in health services, strengthening their leading role vis-à-vis social control.

We have a political axis, which we speak in this sense to strengthen popular participation and social control. To this end, early on, the following has to appear on their agenda when building the agenda: actions aimed at strengthening social control and popular participation (E-T).

In groups, always in waiting rooms, and even in their reception, people can work out this theme [health advocacy] with clients (E-P).

In the waiting room, you can encourage, and guide the clients about their rights, especially violated rights (E-P).

The residents' agendas include actions that strengthen social control and encourage clients' participation in the activities they must comply. Furthermore, preceptors encourage health advocacy by sensitizing them about the importance of encouraging clients to be present at health conferences as a place of active voice.

Residents are also encouraged to establish groups and waiting rooms with the themes of clients' rights and needs. Preceptors also recognize that developing activities that guide clients regarding their rights and needs is essential.

Communication is noteworthy as a significant factor in health advocacy. Dialogue between clients and professionals assists the population with decisions about their health, rights, and duties. In this sense, communication is essential to empower the community to demand HP actions from the professionals[31].

The results of this study corroborate with Figueira *et al.*[27] by considering education practices with citizenship-related themes as strengthening health advocacy in the ESF environment. The authors emphasize that encouraging knowledge exchange between professionals and clients improves the subjects' understanding of their context and gives a space to claim better health conditions.

Despite all the potentialities identified in the RMSFC formative process for developing health advocacy competencies, some areas for improvement are still noticed. In this sense, some realities require building and strengthening spaces where clients feel comfortable expressing their opinions and acting as enforcers and co-participants in the public debate and state management:

We could not work on this issue [health advocacy] at our workplace because the Local Health Council is disabled there. Only the municipal council is active (E-R).

[...] If we are without a doctor, it is a right for the population to have a doctor there. I find it weak. We, as residents, at least the people who work in this part of giving power to the clients. It is not that good (GF-R).

The first statement brings a very restricted health advocacy conception as if the availability of a CLS was the only way to exercise this domain. If there were no CLS in the area where residents operate, it would be essential to raise awareness to reactivate it. Moreover, the lack of a CLS does not invalidate holding activities that promote and strengthen social participation and the empowerment of clients since residents can work on this political axis and the knowledge of clients about exercising their citizenship through the actions in service.

In this treadmill, this account brings to light a significant problem in several locations: the lack and inoperability of the CLS. People manifest a sense of non-belonging to this equipment, in which the community often needs to be more involved in establishing the Councils[32].

As for the CLS, we have persisting difficulties regarding community participation in these spaces related to the scarcity of information and often the need for more knowledge of the counselors' role. In this sense, there is a great need to disseminate the CLS actions, recognize clients' representatives, and increase the training of counselors to perform their activities[32,33].

Moreover, in some cases, the council meetings are kept from the rest of the population, which leads to a lack of CLS visibility. Furthermore, many clients feel dissatisfied with health services, which contributes to the discredit of public policies. The health counselors themselves feel discredited by the population due to the lack of problem resolutions, which results in the population's lack of participation in these spaces[31,33].

Despite these limitations, social participation has been essential for elaborating public health policies[32]. Still, to strengthen popular participation in these spaces, it is crucial to democratize information more, discuss, and exchange ideas about the relevance of representativeness in decision-making spaces[34].

Also was identified the Association of HP actions focused on health advocacy, very much linked to the professional social worker:

It is not relevant to talk about it, especially within my category. The social worker can. It's weak. It's not very good (E-R).

The view of a lack of multidisciplinary work is noticeable in the discourse, implying that the HP actions related to health advocacy are exclusive to the social worker. Manfred *et al.*[35] argue that this perception may be related to the work

Ciência & Saúde Coletiva, 28(8):2227-2236, 2023

performed by the social worker, precisely in mediating people's access to social rights guaranteed by law, involving several areas such as access to education, housing, social security, and health.

However, the multidisciplinary team should incorporate the actions related to health advocacy. In this case, as Figueira *et al.*[27] affirm, a relevant strategy to expand the scope of health advocacy actions consists precisely of the multidisciplinary team's work. In this context, several professionals provide a diverse understanding of the needs of territories, achieve different perspectives, and care more comprehensively, offering actions to defend individuals' interests.

Moreover, the health advocacy activities conducted by residents were also considered insufficient and "weak", showing the need to encourage actions in a multidisciplinary way. Also, the need to awaken in these stakeholders the capacity for activities that emphasize popular participation and social control is evident.

Final considerations

In the capacity for change domain, the activities highlighted were the groups and waiting rooms targeting healthy lifestyle habits through playful and dynamic strategies. However, more than just promoting healthy lifestyle habits is required. It is necessary to develop the autonomy of emancipated individuals, with guarantees and dignified living conditions, achieved from public policies aimed at their real needs.

We should mention that residents are more available to conduct actions in health units since they are in the process of health training through work, which leads us to reflect on the need to expand the teams, with health responsibility for a smaller number of households and work based on interdisciplinarity to guarantee comprehensive care.

For the health advocacy domain, residents advise clients on the importance of popular participation in Health Councils and Health Conferences as an active voice for claiming better living conditions. However, the need for Local Health Councils in the community where residents work was seen as a weakness. Moreover, we should have seen the professionals' performance in encouraging popular participation regarding their rights, and we should have observed their interest in reactivating the Local Health Council.

Finally, our study contributed to unveiling critical interlocution processes between the complex realities that affect daily professional practices within the RMSFC and the complex concept of HPC. Thus, we highlight the need for further research on the development of competencies in professional training and on how professionals are prepared to work in the health services of the SUS.

Collaborations

MJM Ferreira: discussion of the results, critical review of the content, approval of the final version of the manuscript. JP Carnaúba: conception and design of the work and writing of the manuscript, approval of the final version of the manuscript.

References

1. Brasil. Ministério da Saúde (MS). *Política Nacional de Promoção da Saúde: PNPS: Anexo I da Portaria de Consolidação nº 2, de 28 de setembro de 2017, que consolida as normas sobre as políticas nacionais de saúde do SUS*. Brasília: Editora do Ministério da Saúde; 2018.
2. Bezerra IMP, Sorpreso ICE. Conceitos de saúde e movimentos de promoção da saúde em busca da reorientação de práticas. *J Hum Growth Dev* 2016; 26(1):11-16.
3. Puttini RF, Pereira Junior A, Oliveira LR. Modelos explicativos em Saúde Coletiva: abordagem biopsicossocial e auto-organização. *Physis* 2010; 20(3):753-767.
4. Silva JC, Contim D, Ohl RIB, Chavaglia SRB, Amaral EM. Percepção dos residentes sobre sua atuação no programa de residência multiprofissional. *Acta Paul Enferm* 2015; 28(2):132-138.
5. Zapatka SA, Conelius J, Edwards J, Meyer E, Brienza R. Pioneerina primary care adult nurse practitioner interprofessional fellowship. *J Nurse Pract* 2014; 10(6):378-386.
6. Speller V, Parish R, Davison H, Zilnyk A. *The CompHP Professional Standards for Health Promotion Handbook*. Paris: IUHPE; 2012.
7. Dempsey C, Barry MM, Battel-Kirk B, Allegrante JP, Arroyo HVA, Hyndman B. *The CompHP Core Competences Framework for Health Promotion Handbook*. Paris: IUPES; 2011.
8. Pinheiro DGM, Scabar TG, Maeda ST, Fracolli LA, Pelicioni MCF, Chiesa AM. Competências em promoção da saúde: desafios da formação. *Saude Soc* 2015; 24(1):180-188.
9. Silva KL, Araújo FL, Santos FBO, Andrade AM, Basilio NC, Sena RR. O que vem se falando por aí em competências no ensino da promoção da saúde na formação do enfermeiro? *ABCS Health Sci* 2015; 40(3):286-293.
10. Dias S, Gama A. Ensino da Promoção da Saúde em pós-graduação em saúde pública internacional no contexto do processo de Bolonha. *Saude Soc* 2016; 25(3):771-785.
11. Xavier SPL, Pereira AP, Moreira MRC, Martins AKL, Ferreira HS, Machado MFAS. Competências em promoção à saúde à luz do projeto competencies health promotion (comphp): uma revisão integrativa. *Cien Cuid Saude* 2019; 18(1):1-8.
12. Battel-Kirk B, Barry MM. Developing competency – based accreditation for health promotion in Europe. *Rev Med* 2013; 92(2):87-96.
13. Farias JM, Minghelli LC, Soratto J. Promoção da saúde: discursos e concepções na atenção primária à saúde. *Cad Saude Colet* 2020; 28(3):381-389.
14. Souza AM, Tholl AD, Córdova FP, Heidemann, ITS, Boehs AE, Nitschke RG. Aplicabilidade prática do *empowerment* nas estratégias de promoção da saúde. *Cien Saude Colet* 2014; 19(7):2265-2276.
15. Arruda GM. *Colaboração e educação interprofissional na pós-graduação em saúde: estudo de caso da residência multiprofissional em saúde da família* [dissertação]. Fortaleza: Universidade Federal do Ceará; 2015.
16. Casanova IA, Batista NA, Moreno LRA. Educação Interprofissional e a prática compartilhada em programas de residência multiprofissional em Saúde. *Interface (Botucatu)* 2018; 22(Supl. 1):1325-1337.
17. Carnaúba JP, Ferreira MJM. Competências em promoção da saúde na residência multiprofissional: domínios Diagnóstico; Planejamento; Implementação; e Avaliação e Pesquisa. *Interface (Botucatu)* 2022; 26(Supl. 1):e210544.
18. Carvalho PO, Andrade LS, Oliveira WA, Masson L, Silva JL, Silva MA. Competências essenciais de promoção da saúde na formação do enfermeiro: revisão integrativa. *Acta Paul Enferm* 2021; 34:eAPE02753.
19. Barbour R. *Grupos focais*. Porto Alegre: Artmed; 2009.
20. Minayo MCS. *O desafio do conhecimento*: *pesquisa qualitativa em saúde*.14ª ed. São Pulo: Hucitec; 2014.
21. Thompson JB. *Ideologia e cultura moderna*: *teoria social crítica na era dos meios de comunicação*. 9ª ed. Petrópolis: Vozes; 2011.
22. Careganato RCA, Mutti R. Pesquisa qualitativa: análise de discurso *versus* análise de conteúdo. *Texto Contexto Enferm* 2006; 15(4):679-684.
23. Brasil. Ministério da Saúde (MS). Conselho Nacional de Saúde (CNS). Resolução nº 510, de 7 de abril de 2016. Dispõe sobre as normas aplicáveis a pesquisas em Ciências Humanas e Sociais. *Diário Oficial da União* 2016; 24 maio.
24. Silva KVLG, Gonçalves GAA, Santos SB, Machado MFAS, Rebouças CBA, Silva VM, Ximenes LB. Formação de adolescentes multiplicadores na perspectiva das competências da promoção da saúde. *Rev Bras Enferm* 2018; 71(1):98-105.
25. Tusset D, Nogueira JAD, Rocha DG, Rezende R. Análise das competências em Promoção da Saúde a partir do marco legal e dos discursos dos profissionais que implementam o programa saúde na escola no Distrito Federal. *Tempus Actas Saude Colet* 2015; 9(1):189-204.
26. Furtado MA, Szapiro AM. Política Nacional de Promoção da Saúde: os dilemas da autonomização. *Saude Soc* 2016; 25(2):277-289.
27. Figueira AB, Barlem ELD, Tomaschewski-Barlem JG, Dalmolin GL, Amarijo CL, Ferreira AG. Actions for health advocacy and user empowerment by nurses of the Family Health Strategy. *Rev Esc Enferm USP* 2018; 52:e03337.
28. Almeida ER, Moutinho CB, Leite MTS. Family health nurses' teaching practice in the health education development. *Interface (Botucatu)* 2016; 20(57):389-401.
29. Haeser LM, Buchele F, Brzozowski FS. Considerações sobre a autonomia e a promoção da saúde. *Physis* 2012; 22(2):605-620.
30. Gandra EC, Silva KL. Advocacia para a promoção da saúde: sentidos e abordagens na formação do enfermeiro. *REME* 2019; 23:e-1247.
31. Miwa MJ, Serapioni M, Ventura CAA. A presença invisível dos conselhos locais de saúde. *Saude Soc* 2017; 26(2):411-423.

32. Lisboa EA, Sodré F, Araújo MD, Quintanilha BC, Luiz SG. Conselhos locais de saúde: caminhos e (des)caminhos da participação social. *Trab Educ Saude* 2016; 14(3):679-698.
33. Busana JA, Heiddemann ITSB, Wendhausen ALP. Participação popular em um conselho local de saúde: limites e potencialidades. *Texto Contexto Enferm* 2015; 24(2):442-449.
34. Ferreti F, Ferraz L, Kleba ME, Boccalon B, Amorim DC, Comerlat T. Participação da Comunidade na gestão e controle social da política de saúde. *Tempus Actas Saude Colet* 2016; 10(3):51-67.
35. Manfred ALD, Valera FM, Padoim GAA, Salamon VGF, Castro TC. Reconhecimento dos espaços de atuação do assistente social. *Rev Maieutica* 2018; 3(1):105-110.

Article submitted 29/10/2022
Approved 28/03/2023
Final version submitted 21/04/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva

This is an Open Access article distributed under the terms of the Creative Commons Attribution License