

## A precursor experience of the SUS with the participation of Paulo Freire

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THEMATIC ARTICLE

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**Abstract** *The text is based on a round table held at the Faculty of Education (FE) of the State University of Campinas (Unicamp) as one of the activities to commemorate Paulo Freire's Centenary (2021). It aims to record part of his time at the university, from 1980 to 1991, based on the work conducted with FE and the Faculty of Medical Sciences (FCM) through training and extension activities at the Paulínia-SP School Health Center. It also describes and analyses the agendas of the country's re-democratization process, the clashes over public policies in the National Constituent Assembly, and the process of setting up an integrated and universal system of education and collective public health from a participatory perspective.*

**Key words** *Paulo Freire, Popular Education, Public and Collective Health*

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## Introduction

*A specific pragmatism has been imposed on all dimensions of daily life, which believes education is restricted to instrumental training. Based on this conception, education has been limited to training men and women to adapt to the needs of technological life [...] adapted, practical, and operative. This approach trains human beings for the neoliberal capitalist technological model, and all training is an obstacle to the political health of human beings. [...]. On the other hand, the Third World progressive educator's work seeks to overcome certain limitations that are striking at the end of this century. These are global social, economic, and cultural limitations rooted in a particular conception of progress and civilization. [...]. A progressive education emphasizes the human potential to interact and collectively constitute its surroundings. Therefore, overcoming insists on opening up to collective interaction [...]. In this other approach, instrumental and technological competence would be commanded by the need to transform oneself to become more of a person, and, in doing so, the human being constitutes himself collectively with the world<sup>1</sup>.*

The quote above is part of Paulo Freire's reflections with professors, students, and researchers at Unicamp during his time as a professor. He was linked to the university from 1980 to 1991 and worked on various training fronts in popular education, both inside and outside its walls. Ivany Pino, head of the department that welcomed Paulo Freire at the time, says:

*Paulo Freire returned to his country after a long exile forced him to live abroad. The 1964 military coup in Brazil took Freire away from his work at the university, in the circles of culture, and the National Adult Literacy Program. It also interrupted his contact with his family, friends, and the Brazilian people he loved [...]. Freire had to learn to live with other people – Americans for a short time, Europeans, and, above all, Africans, in countries where his theories and methodologies were embraced with strength, credit, limits, and courage! [...]. Back in Brazil, the educator brought images, fantasies, desires, imagination, and the will to resume his personal and academic work, which had been conducted in teams, conversations and dialogues, and culture circles violently prevented and interrupted by the dictatorship... In these new times and spaces of his life, returning to his people [...] part of Paulo Freire's experience as a wanderer*

*of the world was received at Unicamp, at EE, in the Department of Social Sciences Applied to Education, in the academic life interaction with young people in classrooms, professors, and researchers who were his peers [...].*

*With love and patience, which always marked his presence, Paulo spoke and gave his opinion on different subjects and peers, regardless of their theoretical, methodological, political-partisan, or national positions, their personal experiences, and previous acquaintanceships, trying to reintegrate himself into subjects from which he had been distanced for so long. His experience transcended the classroom and extended to social movements, religious groups, grassroots education, liberation theology, and health workers who worked on the outskirts of Campinas and São Paulo through his work at the FE of Unicamp and PUC/SP. One of Paulo Freire's pedagogical practices I would like to highlight was his collaboration with a group of public health doctor-professors from the FCM at Unicamp, who worked with student trainees at a health center in Paulínia, working with residents in public health social movements<sup>2</sup>.*

FE mobilized several professors, students, and researchers to commemorate Paulo Freire's birth centenary with an agenda that retraces the educator's time at the institution, his work, life, and production. In the context of the ephemeris, FE and FCM organized a round table entitled *Paulo Freire and collective health: FCM/Unicamp and the CSE of Paulínia-SP* held remotely on 26/11/2021. Paulínia is a municipality in the inland region of the state of São Paulo. Located in the northwest of the state, it is about 119 km from the capital and part of the Campinas metropolitan region, a high industrial development region. Its population was estimated in 2018 by the IBGE at 106,776 inhabitants (available on: <https://youtu.be/Y-KPM7F5MoE>. Cited 05/07/2023). This article was developed with the participants and resumes dialog established years ago, focusing on the construction of the SUS.

### **Offering health human rights-linked services: an ongoing practice**

Lectures and debates held in the 1970s and 1980s contributed to a critical awareness of health in Brazil, leading to the Unified Health System (SUS) creation. The system was conceived based on the principles of Universality (everyone has the right to health), Comprehensiveness (guaranteeing all healthcare levels), Equity (reducing inequalities), and Social Participation (involving

the population in health decisions). The SUS is considered one of Brazil's most significant social advances despite the challenges it still faces in its implementation. Although it is a milestone, several municipal and state health initiatives occurred during the military dictatorship, given the restrictive political context for political participation. These initiatives aimed to respond to issues such as social inequality, rural exodus, accelerated urbanization, and lack of adequate access to health services. The awareness of democratic freedoms and human rights in the 1970s paved the way for historic initiatives such as the municipal networks of PHC Units and School Health Centers in the state of São Paulo. In the words of Nelson Rodrigues dos Santos,

*The attitude of the then State Secretary of Health, Walter Leser, and his team was of unparalleled competence and lucidity when they proposed the creation of 17 School Health Centers (CSE) under agreements between Health Secretariats, Medical Schools, and Municipalities in the 1970s, with dictatorship in full swing. In the experience in question, I will discuss the rich activities and lessons learned at the Paulínia CSE (CSEP) from 1978 to 1983, when teachers and students intervened in the health reality of the municipal population. It is crucial (apparently common sense today) to relate to the patient comprehensively. Back then, preventive actions were separate from curative actions. Some health professionals and units only did prevention, and others only engaged in treatment, which happened when the reality of life, especially for the most wronged majorities, required both prevention and treatment. The state provided a fragmented response.*

*CSE aimed to provide the population with comprehensive care: vaccinations, basic home sanitation, food, living standards, and prenatal care for normal births. As for the sick, the huge challenge was to work on early diagnosis. Why not catch the disease in its early stages, where diagnosis is much simpler, less expensive, and specialized: a right of citizenship for the person who can resolve their illness before it deteriorates and triggers greater suffering? This CSE was one of the seeds of what is now constitutionally established in constructing universal, comprehensive, and equitable health-care, simultaneously preventing and treating.*

*The dictatorship closed down CSEP in 1975 as if it were crushing an animal's paw on it. Repression affected the Center and Unicamp itself, just as many public entities bowed to the dictatorship's paws. It is important to record this because it was an institutional event, the subjection of a univer-*

*sity like Unicamp, whose role and obligation of a public institution is to interact in research, teaching, and extension.*

*In 1978, three years after its closure, the Paulínia CSE resumed its activities, reducing its services to a small number of pediatricians, adult physicians, and gynecologists in the face of a demand that exceeded availability. However, leaders from the Pan American Health Organization (PAHO) and Unicamp sought to return to CSEP practices. I was responsible for coordinating this task.*

*We worked hard to restart deactivated programs and internships for residents, interns, and undergraduate medical and nursing students. Everything was done carefully because the country was still under dictatorship, and the proposed initiatives were extremely sensitive to conservative sectors and the government, such as placing undergraduate and graduate medical and nursing students within the population in activities the civilian-military government condemned. Internships were seen as dangerous, as was increasing the number of teachers at the CSEP. Despite these restrictions from the authoritarian system, the departments of general practice, gynecology/obstetrics, and pediatrics received more teachers to rotate in Paulínia to expand their activities.*

Hideo Aoki speaks next:

*In the 1980s, José Aristodemo Pinotti, from the Department of Obstetrics and Gynecology at the FCM and dean of Unicamp (1982-1986), recognizing Paulo Freire's national and international contribution to what has come to be called university extension, invited him to advise this sector of the Dean's Office and accompany several programs, projects, and actions. Training doctors and nurses, monitoring CSE Paulínia residents, and contacting patients, families, the community, and health are considered popular education.*

Aoki was an undergraduate medical student at Unicamp when Professor Paulo Freire came to CSEP. His interventions influenced him, and his lessons were incorporated into the perspective of an integrative action among FCM professionals towards a multi-professional approach that involved teachers, doctors, students, residents, health workers, patients, and the community. Everyone was equally crucial to the success of the Education and Collective Health work. He remembers Prof. Nelson leading St. John's festivities with a scarf around his head, serving the participants. This professor was already a reference at PAHO and one of the creators of the Unified Health System (SUS), relating to the students horizontally, as is still the case today. Since he

was still very young, Aoki ponders that he had no idea of the magnitude that this experience would leave on his upbringing as a doctor.

Prof. Nelson and Prof. Silvia did a lot of work for public health in Paulínia. The work was governed by a tripartite agreement involving Unicamp and the municipal and state governments. At some point, Paulínia Municipality unilaterally broke the contract, causing discontinuity in training, internships, and residencies for the students, as mentioned by Prof. Nelson, who also highlighted the resumption. On these facts, Aoki comments:

*Sometimes municipal health secretaries do not see the improvement that working together can achieve in public health. The project worked very well, and the Municipality's vaccination coverage statistics were the highest in the country, reaching around 95%. However, everything in health is very politicized, and the drafting, implementation, financing, and evaluation of public policies depend on people in charge and political will.*

They were all co-participants in the activities developed at the Santa Casa de Misericórdia de Campinas (SCMC), where the FCM/Unicamp and the CSEP were based. As a student, Aoki interacted unceremoniously with the professors multi-professionally, valuing the negotiated treatment through collective healthcare. Having had interdisciplinary and interprofessional experience, he points out:

*Today, neoliberalism is lashing out at us from all sides. It has erased this perspective of popular and public education in health, which has a detrimental effect on the quality of training of undergraduate and postgraduate students and outpatient care. However, some professionals dedicate themselves to humanist education, inducing an interactive approach to medical practice and health promotion. The very ethics of the profession make doctors responsible for a form of medicine that protects and cares for patients. Otherwise, the quality of medical training will suffer. Students must be responsible for patient care and must not be mere test takers and professionals who misinterpret results and misdirect diagnostic hypotheses. Many doctors do not examine, ask questions, or listen to others. We learned these procedures from Prof. Paulo Freire when he insisted that the priority was to listen to the other person and that the doctor's relationship with the health team, patient, family, and community was an exchange of experiences and knowledge. We are all interconnected because the doctor is also a community member, which is a reality.*

*Then, the multidisciplinary, dialogical, and interconnected perspective formed us as students, residents, doctors, and professors at Unicamp. The students identified many inappropriate examples as models we did not want to repeat. Through simple attitudes and respectful behaviors of caring for others, some professors marked us powerfully and effectively.*

*Care at the SCMC and CSEP involved residents, students, and professors in a powerful outpatient training program. We followed the example of Prof. Nelson in Collective Health and Prof. Ronan José Vieira in Internal Medicine and Emergency. They were there and taught us through respectful conduct with patients, an inclusive attitude with the team, proper procedures, and assertive intervention, which defined our training as doctors. Everyone met at the SCMC and CSEP, and we learned a lot from talking, evaluating, and organizing training and work. After we moved to the campus, to Unicamp's Hospital das Clínicas (HC), we isolated ourselves in our offices, and the meetings declined, which saddened our relationships.*

One lesson that emerged from that experience of training doctors was the search for the best care for patients, even though funding conditions and the lack of beds created many relational, operational, and administrative difficulties. According to Paulo Freire, Health Education, the SUS, and Popular Education have many converging points because they value popular knowledge and care practices. "Our experience and the living conditions of our patients confirm this", commented Aoki. The Paulo Freire method displays education as a political act committed to transforming the world. Aoki continues:

*Is health any different? Is it about transforming the health condition of patients? Is it possible to find interesting solutions by integrating the knowledge of doctors, teams, and patients through a shared power relationship? These questions were answered by the 1988 Federal Constitution (FC) when it started to design a health and education model for all. Prof. Nelson was one of the creators and implementers of the SUS, one of the most advanced systems on the planet. The 1988 Federal Constitution draws health closer to human, social, and universal rights. It is therefore virtuous to remember the links between Paulo Freire and the advice given to the FCM team working at the Paulínia CSE as an important and successful action regarding training, outreach, and the realization of rights.*

Prof. Nelson's comments followed during the discussion:

Regarding the population profile, it was striking to see that the waiting rooms in the outpatient clinics started to become too small for so many patients. People came in the early morning hours before the CSE opened and formed queues. Concern began to arise about the arrival of people with more advanced illnesses and whether care should start with them or with those who arrived first. How would the necessary early appointments be? What were the workplaces and homes like in the outlying neighborhoods and rural areas? This jostling and tension in nursing and medical care at the CSEP would be the beginning of the reproduction, albeit on a smaller scale, of what was happening in the more traditional outpatient clinics in all medium-sized and large cities, i.e., the difficulty of making an early diagnosis that would prevent illness, or late care with greater suffering and cost. Contact was made with the places where this population had been before arriving at the CSE to counter this logic, and visits were made to industrial and agriculture and cattle-raising companies. There were two huge farms where many of the population lived and worked. Furthermore, Paulínia is an oil hub with dozens of chemical industries around the refinery and satellite industries, with thousands of employees who live there or in neighboring towns. Most had an occupational doctor as a legal obligation. We asked ourselves: How were the causes of illnesses, diagnoses, early treatment, and health at work? We had a large company that was a railroad terminal and trucks that transported cereals with tons of corn, soybeans, beans, and other grains, which arrived daily to be stored and redistributed by dozens of manual workers.

Prof. Nelson summarizes his work as a coordinator:

We started with a few residents and a lecturer rotating visits to these places, setting up a small clinic for weekly care in each of these companies. For example, on one farm, we found that the principal health problem for these adults was simply alcoholism. We asked ourselves: what answers could there be for alcoholic rural workers who came to the clinic with several symptoms in the organs of their bodies affected by alcoholism?

There was a case of a quarry worker who was urgently brought to CSEP from work with hypertensive crisis symptoms. The peer who attended suggested visiting this quarry. At the time, we could not ascertain and prove the causes of this hypertension, but one of the possibilities was the psychological stress caused by the explosives used to break up the stone and turn it into small granite blocks. Eighteen people were working there. We

measured everyone's blood pressure, and only one had normal pressure. The others had hypertension and nervous tension from the work of exploding and running away to avoid being stoned. There was a history of traumatic accidents and one death as a result of these explosions. Almost all of those hired were informal workers. As for the farm, it was agreed with the manager to set up a small local clinic once a week and, as for the quarry, a monthly visit to monitor pressure and encourage the company to adopt preventive measures in its work operations.

Also, in Paulínia, we visited a chicken factory that employed around forty women. The chickens were killed and immediately placed on a conveyor belt, which butchered, separated them, removed the skin and the entrails, and they came out at the other end of the conveyor belt ready to be sold in the supermarket. The chicken was transformed into 20, 30, or 40 butchered pieces. The workers were exposed meter by meter on this treadmill. The number of fainting spells was noteworthy, and one of the women fainted more than the others due to nervous tension from hours of standing and exposure to that setting. This pathological event appeared at the end in the drop in pressure and the fainting spells. We had lung diseases at the grain terminal. The loading and unloading of train wagons and grain trucks raised dust that we could not see each other from a meter away. Workers were exposed to this all day, and soon, lung diseases were detected.

We tried to combine early diagnosis of those who fell ill before the others with working with companies' owners to make the working environment healthier. It was a traumatic and surprising experience for the CSEP team.

This learning led us to propose a circulating outpatient clinic once a week for early diagnosis and, from a preventive viewpoint, to improve working conditions and the environmental conditions that led to illness. The CSEP did not have the structure and staff to do this. So, we mobilized the authorities, the city council, and state sectors to issue precautionary measures to improve working environments.

From this experience, an extremely human lesson was the difference with which patients relate to the CSEP. In the circulating outpatient clinic outside the Center, before the disease diagnosis, the patient spoke more confidently and in a more autonomous tone, like someone telling their life, feelings, and fears of getting worse. There, stories flowed with greater clarity and richness of causality than at the CSEP outpatient clinic. The privi-

leged location of primary healthcare was clear to us: close to homes and workplaces.

These initiatives were the subject of conversations with Paulo Freire at the CSEP. He was impressed by the stories about what the workers talked about and how they became aware of their illness by telling their health story and that of their families. The professor's proposal at CSEP was to interact with the doctors and nurses who worked in the children's, adult, and women's areas. He made a point of talking to everyone, including staff and clients. On one occasion, he borrowed a lab coat and a small white apron. He put it on so that he could talk to the patients and test the relationships they would establish with the nursing staff and anyone who presented themselves as an educator. When we talked about the possibility of the health system reaching the people's place of life and work, he told us: "You are facing a knot that needs to be untied, and I confess that I also feel implicated and challenged in this quest that you are processing".

We did not get to where we wanted to be, but we made much progress and even saw where the SUS should be. The design of highly localized and humanized care for the population was only achieved in the 1988 Constitution. Unfortunately, in the 34 years since the Constitution, no matter which party coalition was in power, the State has put the brakes on the complete application of the SUS guidelines set out in our Magna Carta and, to this day, we are still fulfilling a tiny part of the population's constitutional rights. We should underscore two more initiatives, one focused on education and health, and Prof. Nelson continued:

*In the first cycle of elementary school, a school health program was discussed with the students' teachers and parents. When they mentioned worm eggs in feces, the children's eyes widened. Then, a CSEP microscope was brought to the school, and worm eggs and bacteria were shown on slides. Thus, they saw a world of beings invisible to the naked eye for the first time. A nutritionist also talked to the students about food and school meals. Important yet simple, obvious, and basic actions.*

The other initiative was expanding activities. With the urban growth of Paulínia, CSEP proposed to the Municipality that it make two properties available, one in a suburban neighborhood and the other in a recent housing development, both with a high population density, to install two PHC units as an extension of CSEP, which had a positive effect.

These were the early years of the 1980s when the provision of PHC Units was advancing at a

national level and consolidated in the larger municipalities. This intervention impacted the 1986 Eighth National Health Conference, which debated and approved the SUS guidelines. At this point, Paulínia's Municipality started building the Municipal Hospital and municipalized all the health units based on the CSEP.

To conclude, I would like to stress that bringing health to the population is not a stroke of genius nor an unattainable scientific and technological discovery. It is simply the democratization of what has been known for a long time, making knowledge available to the population in their living and working spaces. With great satisfaction, our term at CSEP was succeeded by Gastão Wagner de Souza Campos, a renowned and competent hygienist and professor at Unicamp, who continued to make innovations in favor of the population and health workers.

According to Prof. Silvia Maria Santiago,

*Paulínia was a special territory, not because of its financial status as a privileged municipality, which raised much money as a result of Petrobras and the multinationals that were there, but because of its ability to promote actions and reflections on the social, economic, political, and cultural reality of the place and the country, based on the people who moved around there and who left significant achievements, particularly in Education and Health. The training the students received there predestined them for a type of care and engagement with public health, both from a collective and individual viewpoint, based on community action to address need-related health issues. The desire for qualified professional training was also marked by a perspective pointing out that the doctor did not have all the answers; he needed the patient, peers, and the team to diagnose and find the best solutions. The production of a way of thinking and practicing education and health mixed the contributions of academia with those of different community players, pointing towards an equitable and participatory vision of health.*

The circulation of thought focused on the desire to understand reality and exploit nature less, including human beings, university work, health services, and community education. This agenda was maintained from the 1970s to the 1990s, which included the passage of Paulo Freire and new managers who were in the Municipality and open to more democratic initiatives.

A community approach pointed to a different future, including the environment, associated with a vision of health in the city and not restricted to individualized outpatient care. A dimension of

*more solidary, communal lives of mutual support was being discussed, and happiness was seen as a collective possibility and not just an individual one. It was a very ambitious proposal, and the journey involved respect and love.*

When we talk about the thoughts circulated in Paulínia between the 1970s and 1990s, the references are to the influences and constructions in the social areas that went hand in hand in the Municipality, particularly in children's health and primary education. As Aoki recalls, "As FCM students and residents, we were privileged to take advantage of an unforgettable innovation in the training of professionals as political beings defending public policies and reducing inequalities".

We should remember the current of thought that preceded Paulo Freire's passage, which was that of Prof. Sérgio Arouca, at the time in Collective Health, and a whole group of medical professionals, educators, social workers, and health professionals who wanted to formulate ways of providing care closer to the population. Then, doctor and Prof. Arouca from FCM/Unicamp sought the collaboration of peers from the university's humanities to build a new way of understanding the health-disease process and escape the hygienist traps, which are always very prescriptive. The idea of this group was that health action should build freedom and not prescribe "correct ways of living". We managed the health system then, culminating in the 1988 Constitution and the 1990 SUS.

These exchanges of thoughts brought the country's political-economic-social issues to the interface with illness. In other words, they were not detached from the more general issues of politics and disease-triggering situations. The issues of Education and Health became strategic. However, not an education based solely on not getting sick, as proposed by the WHO based on the concept of self-care defined as "the individual's capacity to promote and maintain health and prevent and address diseases with or without a health professional's support". From this perspective, illness is passed on as the individual's responsibility without seeking to understand the social processes that cause diseases. On the contrary, we envision a health system that builds freedom and does not blame.

Although Sergio Arouca and his group left Unicamp in 1975, before Paulo Freire was hired, they left fertile ground for understanding health practices based on the discussions brought by the educator. Paulínia was receptive to health projects and popular education. Prof. Nelson gave

continuity to thinking about health in a non-prescriptive way that incorporated the community's knowledge to obtain a dignified citizen life.

Paulo Freire's discussions broadened the understanding of the children's scope beyond the office. Who were those children? Who were their relatives or guardians? Education and Health in Paulínia began to be imbued with this relational, contextualized, and dialogical approach. A movement of pediatricians was circulating between the FE and the Paulínia health system: Drs. Vera Miranda, Luzita, Maria de Lurdes Zanolli, Eduardo Gamba, and then Maria Ângela Antônio. They all had an FE experience aligned with Paulo Freire and Ivany Pino. Discussions of real-life situations in child healthcare focused on the context, as proposed by Paulo Freire. The client was placed at the Center of the care process. The reason for the existence of a service, a center, and a health network is always the client, who appears as a fundamental partner in thinking about health and disease in the context of the doctor's office, the community, social relationships, and work. The most important thing was not to discuss new concepts but to abandon the authoritarian practices of signs and symptoms of disease and, above all, to act in the micropolitics of care, the doctor-patient or health professional-client relationship, and the relationships between professionals and the management. This movement foresaw an essential pillar of the SUS, which aimed to strengthen the exercise of citizenship towards realizing rights.

It is also necessary to mention medical students' learning because the CDE's environment was prepared for traditional, technical teaching. However, the context faced us with the reality of lives there seeking care for their needs. We had to develop solidarity as a healthcare tool and put all our technical knowledge at the disposal of the cases and situations.

*Here, Aoki and I (Silvia) were residents and then professionals. We put ourselves in the reality of the client's life, and our learning did not only occur within the health services. We were often taken to farms, neighborhoods, and companies to work with occupational health, understanding the processes of work and illness and talking to the people who were our patients at the Center. Our learning environment comprised the outside (risk situations) and the inside (outpatient clinics, groups for pregnant women, hypertensive patients, and pediatrics). Education as a "practice of freedom" was transposed to Health and Health Education in individual and collective contact, interacting with*

diverse groups, urban and rural areas, and public and private institutions. The exercise was an invitation for professionals and clients to share and build new possibilities for health. The fight against oppression occurred in the context of the client's life and the republican exercise of Medicine. It reminds me a lot of Foucault's "The Care of the Self", but focused on community care political action. Based on these issues, we learned from fearless teacher-builders like Paulo Freire to organize ourselves in an open, inclusive, and receptive way without fearing the client.

Our issues and challenges at the CSE became:

- The health services needed to want people to be there and to visit the multiple territories of health professionals and clients. The health services and their workers needed to understand their clients as a richness and the reason for the existence of the health facilities.
- Health workers needed to understand that learning and teaching occur in the relationship with clients, despite a different initial expectation that led to a more vertical power relationship between the doctor and the patient;
- Health services deserved to be configured as places where knowledge is exchanged, in other words, Health Education should be at the heart of interventions at any point in the system, especially in collective and individual primary care.
- Technical performance should always be of the highest possible quality of technical knowledge, available equipment, and relational technologies developed in care;
- Health work could express the dimension of pleasure and enjoyment as a strategy based on interpersonal relationships.

These discussions about the interfaces between Education and Health have built a way of doing health. More complex areas, such as surgery, intensive care, and some very technological specialties, such as otorhinolaryngology and specialized gynecology, had their outpatient clinics in the PHC network. The way of treating and connecting with clients in the primary network contaminated how the hospital worked, creating a close partnership between hospital professionals, the primary network, and clients, even during hospitalizations. Interactions between primary care and hospital workers were a partnership; many worked at both levels. This training was emancipating for the people there, and Paulo Freire's passage was unforgettable and is still incorporated into our practice today.

## Final considerations

At the round table, Débora Mazza referred to Gastão W.S. Campos, presenting the SUS as "a public health system, a non-market space, which strengthens universal social policies and is responsible for the exclusive care of 75% of the Brazilian population"<sup>3</sup>. She cites Tereza Campello's research on the dimensions of inequality in Brazil and its effects on health problems, pointing out that this field reflects the socio-economic conditions of the population in direct relation to "the disorderly urban growth, the lack of basic sanitation and quality water, housing conditions, work, food, education, and ethnic/racial issues". It suggests that "many health indicators directly result from other public policies or their lack thereof"<sup>2</sup>. It shows that in the post-constitutional period up to 2015, national PHC care coverage jumped from around 30% to around 65% and says:

*Health policies began to recognize the specificities generated by situations of social vulnerability and demanded new models for organizing services. Initiatives such as the More Doctors Program, the Family Health Support Centers, the Street Clinics, the Riverine PHC Units, the Mobile Oral Health Units, and the National Comprehensive Health Policies for the Black Population have added to the expanded network and the increase in SUS services<sup>4</sup>.*

The data presented on the declining child mortality, expanded primary care services, equity of services between all regions, increase in prenatal care visits, care for children aged 1 to 4, family healthcare, and a reduction in infant malnutrition rates, hospital admissions of minors, TB cases, and detected leprosy, ensure that the debates of the 1980s and 1990s unfolded in social education and health policies implemented at national level by democratic governments committed to a vision of more significant State presence ensuring social welfare.

However, we have experienced a market-driven, violent, and polarized strategy of doing politics under the slogan of more market and less state in recent years, stimulating doctrinaire, authoritarian, intimidating, and dogmatic positions that weaken the democratic and universalist perspective of universal social policies such as the SUS, Primary Education, and the Unified Social Assistance System.

Adriana Varani emphasizes that it is necessary to resume Education and Health practices as the common good and the public sphere. The



progressive perspective brought by Paulo Freire at FE, FCM, and the Paulínia CSE illuminates our steps, collaborating to overcome econom-

ic, political, social, and cultural limitations, and emphasizes the human potential to interact and establish itself collectively.

### **Collaborations**

All the authors participated in the organized event and drafted the article that resulted from it.

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