Popular education in oral health: analysis of educational practices in Primary Care

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Abstract: Popular Education in Health has emerged as a guiding principle for educational practices in Primary Care, making them more dialogic and in tune with popular culture, based on the principles contained in the National Policy for Popular Education in Health. This study analyzes the educational practices of dental surgeons in Primary Care, seeking to identify the principles of Popular Health Education in these practices. The data were collected through semi-structured interviews with 39 dentists from the municipality of Fortaleza-CE, in which three corpora of analysis were identified based on three professional profiles: passive, striving, and empowered. No principles of Popular Health Education were identified among the passive dentists. In the case of the striving dentists, only the principles of dialogue and the shared construction of knowledge were identified. In the empowered profile, all the principles were identified, and the use and knowledge of Popular Education in the daily lives of these professionals were noticeable. The conclusion is that there is still a need to intensify and direct the process of Permanent Education of professionals using Popular Education as a guide, enabling more dialogic and problematizing educational actions with the community.

➤ **Keywords:** Health Education. Oral Health Education. Primary Health Care.

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Introduction

Health Education is the educational process of building knowledge that involves the relationships between health professionals, the managers who support these professionals and the population that needs to build their knowledge and increase their autonomy in care, being an instrument for Health Promotion through the articulation of technical and popular knowledge (Ferreira *et al.,* 2014; Ramos *et al.,* 2018).

Acting as a pedagogical process, Health Education in Primary Care requires the development of critical and reflective thinking, allowing reality to be unveiled and transformative actions to be proposed that lead to the individual's emancipation as a historical and social subject, capable of proposing and having a say in health decisions to take care of themselves, their family and their community. In addition, as it is essentially an intersectoral and interdisciplinary activity, it requires collective and innovative construction, whether in the framework adopted, the strategies used or the technological resources, thus shifting the focus from disease and the simple prevention of illnesses to Health Promotion and comprehensive care (Machado; Vieira, 2009; Freitas; Mandú, 2010).

In the context of oral health, health education is advocated by the National Oral Health Policy and is an important tool for reducing risks and changing epidemiological scenarios. In addition, oral health is an integral and essential part of the individual's health, and dental surgeons in Primary Health Care (PHC) must ensure that their assigned population receives comprehensive care, combining clinical action with preventive and educational practice (Brasil, 2004; Alves; Aerts, 2011).

Proposing educational practices that are sensitive to users' needs is part of an emerging discourse in health education - the dialogic model. This model is based on proposing educational practices that are sensitive to people's needs and has dialog as an essential tool through which they become capable of critically reflecting on their reality and improving their coping strategies. People cease to be objects and take on the status of subjects of educational practices, which are carried out based on an understanding of different realities (Alves, 2005).

In this context, Popular Education in Health (EPS in Portuguese) emerges as a social movement and practice with a view to making health more humanized and in tune with popular culture. Based on Paulo Freire's principles of Popular Education, it values educational practice from a horizontal perspective of the

relationship between subjects, encouraging interpersonal exchanges and seeking to understand popular knowledge through dialogue. This methodology recognizes the user as a subject capable of establishing a dialogical dialogue with the health service, developing a critical analysis of their reality and overcoming the cultural distance between the services and the assisted population in a participatory way (Bonetti; Pedrosa; Siqueira, 2011; Vasconcelos, 2011).

In 2013, EPS was institutionalized through Ordinance No. 2,761, establishing the National Policy for Popular Education in Health (PNEPS-SUS), which includes some principles that involve political, ethical and methodological dimensions that give meaning and coherence to the praxis of EPS. These are: dialogue, problematization, loving kindness, shared construction of knowledge, commitment to building a democratic and popular project and emancipation (Brasil, 2013).

Dialogue is the exchange between subjects and their historically and culturally constructed knowledge, which takes place when each person respectfully makes what they know available to the other. It represents a critical perspective for building new knowledge, based on listening to others and valuing their knowledge and initiatives. The problematization principle proposes the construction of health practices based on the critical reading and analysis of reality, based on the subjects' previous experience, the identification of limiting situations in their daily lives and the potential to transform them (Brasil, 2013).

Amorosity recognizes the value of affection as a structuring element in the search for health and leads to bonds, mutual understanding and solidarity, seeking to establish relationships of trust and acceptance between people (Brasil, 2013).

The shared construction of knowledge consists of pedagogical processes between people and groups with different knowledge, cultures and social backgrounds, with a view to collectively understanding and transforming health actions. As a result of the dialog, it allows the construction of practices and knowledge in a participatory way, uniting technical knowledge with popular knowledge (Brasil, 2013).

The commitment to building a democratic and popular project is guided by the prospect of creating a just, supportive, democratic, egalitarian and culturally diverse society that permeates social struggles, with popular subjects and social movements as protagonists. The principle of emancipation promotes the overcoming and liberation from all forms of oppression, discrimination and violence that still exist

in society, strengthening the sense of collectivity in the perspective of a just and democratic society (Brasil, 2013).

However, despite the widespread dissemination of educational methodologies using the EPS framework, oral health educational practices are still dominated by actions centered on the transmission of knowledge, one-way communication, with a focus on disease and cure, using traditional approaches. Because they are centered on the dental surgeon, these approaches end up not encouraging individuals to reflect and achieve autonomy in their care, in addition to not taking into account the complexity of social determinants (Lemkuhl *et al.,* 2015; Vasconcelos; Cruz; Ernande, 2016; Mendes *et al.,* 2017).

Furthermore, even with the notion that practices based on the principles of EPS should be included in daily work, many health professionals relegate educational activities to a secondary role in care planning and actions (Carneiro *et al*., 2012).

With the need to promote a new approach to Oral Health Education, based on popular participation and truly transformative educational actions, this study aims to analyze the educational practices of Primary Care dentists in the municipality of Fortaleza-CE, from the perspective of EPS, seeking to identify the principles contained in the PNEPS-SUS in these practices.

Methods

This is a cross-sectional, descriptive and exploratory study, which used the principles of EPS contained in the PNEPS-SUS as its theoretical framework, with a qualitative approach. The approach was chosen because of the need to capture the uniqueness of particular situations and their characteristics, allowing us to work with the universe of meanings, aspirations, beliefs and attitudes, which corresponds to a deeper space of relationships, processes and phenomena that cannot be reduced to the operationalization of variables (Minayo, 2014).

Fortaleza is divided into six Health Districts, with the Municipal Health Departmen (SMS) as the managing body. The municipality currently has 118 Primary Health Care Units or UAPS, of which 16 are in Regional I, 12 in Regional II, 19 in Regional III, 13 in Regional IV, 27 in Regional V and 31 in Regional VI. Coverage of the Family Health Strategy (ESF in Portuguese) in Fortaleza is 70.38%, and of oral health teams (EqSB in Portuguese), 50% (Fortaleza, 2023).

Given the objectives proposed for this study, the subjects of this research were PHC dental surgeons; and the inclusion criterion was that they were permanent civil servants working in the ESF in the municipality of Fortaleza. According to data from the SMS, of the 412 dental surgeons distributed in the six Regional Health Offices, dentists who were in commissioned/management positions and on health leave, maternity leave, among others, were excluded. Based on these inclusion and exclusion criteria, a total of 279 dentists was estimated.

Based on this number, the SMS's Special Oral Health Management and the Regional Oral Health Coordinating Offices were asked about the UAPS with EqSBs that stood out for their successful and/or innovative educational experiences, in order to select an intentional sample.

In order to define the number of participants, Minayo *et al.* (2014) teach that an ideal sample is one that reflects the multiple dimensions of the object of study and makes it possible to cover the totality of the problem being investigated in its multiple definitions. We therefore opted for a purposive sample, in which the selection of elements stems above all from the concern that the sample contains and reflects certain dimensions of the context to be studied.

The sample selected for the study was made up of 46 dentists working in 12 UAPS, distributed across the six Regional Health Offices. After excluding dentists who knew the purpose of the study and refusals, the final sample consisted of 39 participants.

The data was collected from November 2021 to February 2022 by a researcher who had no relationship with the participants, through interviews that used a semi-structured script in three axes: 1) Oral Health Education practices carried out by dental surgeons in PHC; 2) EPS principles present in oral health educational practices; and 3) Potentialities and challenges, according to dental surgeons, for carrying out these actions.

The interviews were carried out in the dental offices of the UAPS themselves, according to the schedule and availability of each professional. The audios of the interviews were recorded and later transcribed by the same researcher and the dental surgeons interviewed were identified in their statements by the letter E and by numbers (E1, E2), as a way of guaranteeing the anonymity of the participants. The average interview time was 30 minutes. In addition to the interview, a field diary was used to describe the impressions and feelings that emerged for the researcher after each interview.

After reading the interviews and the field diary in depth, all the material was comprehensively read and the speeches categorized, using the Discourse Analysis (DA) method for the analysis. For Pêcheux (1993), language is the materialization of speech, with material and symbolic planes, and the discourse produced by speech is related to the socio-historical context in which the individual is inserted. In addition, DA makes it possible to understand individual and collective, historical and socially determined discourse, highlighting elements that allow health practices to be redirected (Rocha; Deusdará, 2005).

Based on the testimonies collected in this research, the analysis corpus was identified using modalities of professional practice evidenced in the study by Terra (2018) as a reference. Thus, three analysis corpora were identified: passive dentist, striving dentist, and empowered dentist.

It is important to note that the interviews were conducted only after the Informed Consent Form was signed, and the project was approved by the Research Ethics Committee of the Ceará School of Public Health (ESP-CE) under opinion no. 5.078.770. The research was self-funded by the researchers and is one of the results of the master's thesis "Popular Education and Oral Health: Analysis of the Educational Practices of Dental Surgeons in Primary Care." There are no conflicts of interest involved.

Results and Discussion

Regarding the characterization of the study sample, 27 (69.2%) were women, with an average age of 48 among the interviewees, ranging from 38 to 66 years; 19 (48.7%) had between 16 and 20 years of professional training and 14 (35.9%) had been working in the Family Health Strategy for the same length of time. With regard to postgraduate studies, 25 (64.1%) of the interviewees had some kind of specialization course and 23 (59%) in Family Health or Collective Health. However, only 14 (35.9%) of the dentists had taken a course or training involving knowledge of Active Methodologies and/or Popular Education.

It was identified that even though they were subjected to the same economic and social situation, working in the same context and in the same municipality, there were different behaviors and perceptions of educational practices, which were grouped into three professional profiles. Chart 1 shows the characteristics of

the main educational activities, as well as the principles of EPS evidenced in the practices of each professional profile.

Table 1. Comparative summary of the passive, striving and empowered professional profiles. Fortaleza-CE, 2022

CATEGORIES	Sub-categories	Professional profiles		
		Liability	Hardworking	Empowered
FEATURES PRACTICES	Educational practices	Lectures and collective preventive activities	Operative groups and actions in the waiting room	Operative groups, playful practices and conversation circles
	Main place of action	School / nursery environment	Health Unit	Social spaces in the territory
	A broader view of oral health	Incipient, focusing on oral health issues	Yes, addressing different themes	Yes, addressing different themes
	Type of educational approach	Traditional	Mainly traditional	Problematizing
	Blaming	Strongly present	Present	Absent
	Use of active methodologies	No	Incipient	Yes
	EPS concept	They don't know and don't try to conceptualize	They know little, but they try to conceptualize	They know
	Action planning	No	Incipient	Yes
PRINCIPLES OF EPS	Principles identified in the practices.	Not identified	Dialogue Shared knowledge building	Dialogue Problematization Shared knowledge building Love Building a democratic and popular project Emancipation

Source: The authors.

It should be emphasized that the classification into profiles does not define the professional, but rather their performance in educational practices at a given time, based on all the conditions and possibilities of their professional practice. There was no relevant association between the type of profile and the characterization by gender, age, length of professional training and time in the ESF.

Passive dentist and the principles of EPS

This profile was found in 14 (35.9%) of the dentists interviewed, and it was observed that most of them had never heard the term *popular education*, and also had a lot of difficulty conceptualizing it, even empirically. Of the 14 dentists in this profile, five had a postgraduate degree in Family Health or Collective Health, and only one had taken a course on popular education.

These dentists had little participation during the interview, as well as appearing tired and discouraged in relation to their own work process, as well as in their educational practices, which were mostly carried out using traditional educational approaches. These professionals were indifferent to their own actions and to the political/social context in which their population was inserted.

No EPS principles were identified in the statements of the dentists in this profile, nor were there any references to actions with problematizing educational approaches or other active methods that allowed interaction, dialogue and the exchange of knowledge between professionals and the community. The Health Education actions of these professionals are still based on the transmission of knowledge, with one-way communication, characterizing actions centered on the dental surgeon that do not encourage reflection and autonomy. The actions most often carried out by dentists of this profile are lectures, with themes related only to oral health, and preventive activities, such as supervised oral hygiene and topical fluoride application in the school environment.

> We usually give lectures, talking more about oral health. (E7)
>
> We give talks [...] and usually talk about oral health. And sometimes we do oral hygiene instruction and fluoride application." (E4)

These findings are in line with other studies which show that many health education actions are still based on traditional paradigms of educational-preventive interventions, focusing on supervised oral hygiene, lectures and fluoride applications (Mendes *et al*., 2017; Matos; Gondinho; Ferreira, 2015).

It is known that although prevention practices are considered relevant actions and capable of reducing the incidence of oral diseases, they must be linked to educational processes that make "sense" to the population, with approaches that encourage self-care and increase the exchange of knowledge between the oral health team and the community. In addition, educational practices based on the

simple transmission of information based on the hygienist approach (anchored in the behaviorist paradigm), with predefined themes only restricted to the "mouth", do not express any concern with problematizing health, nor with the search for strategies capable of enabling the continuity of effective and truly transformative educational actions (Pauleto; Pereira; Cyrino, 2004; Brasil, 2018).

In this professional profile, the process of blaming the community for its lack of participation in educational practices was unanimously identified.

> I think there's a lack of education among the population. They have no idea what the educational service we're doing represents. They don't want to take part and they don't value it." (E7)

Victor Valla (1993) described this process as being the product of traditional health education practices that are limited to prescribing individual behaviors suitable for achieving good health, leading to the interpretation that the population is the main culprit for their illness. With this reasoning, we often find prescriptive educational activities, treating the population passively, transmitting technical knowledge about diseases and how to take care of health, disqualifying popular knowledge and the living conditions of these populations. Thus, the monopoly of technical knowledge puts the accumulated knowledge of the community in the background, not taking into account their experiences. The individualization of blame therefore becomes the "explanation" for an inefficient collective practice (Valla; Stotz, 1989; Vasconcelos, 1999).

These educational barriers need to be overcome in order to build more dialogical methods that replace the behavior-modeling attitude with an emancipatory one. In addition, there is a need to awaken interest in educational work among these professionals, as well as recognizing and tackling problems related to health education.

A hard-working dentist and the principles of EPS

This profile was found in 12 (30.7%) of the professionals interviewed, showing their participation and effort in relation to their work process and educational practices. This profile already shows a better conceptualization of the term *popular education*:

> I think it's a working strategy that brings us closer to the user, to the citizens. In a more appropriate language, we allow them to participate [...]. Also noting that they have their own culture. I think it's an exchange (E2).

Of the 12 dentists in this profile, nine have a postgraduate degree in Family Health or Collective Health, which is reflected in the way they care for the health of their community, with the main educational activity carried out by this profile being group practices, carried out within the UAPS. However, this qualification does not guarantee that problematizing approaches are a priority in these practices, since only two professionals have taken a course on this subject, which ends up having an impact on the educational practices used.

> In the elderly group, the nurse in my team is in charge. She comes in to talk about the topic, then she tells us what we should talk about too (E2).

There is still a certain distance between these professionals and the social context of their community, with little reflection on their potential to transform and build autonomy through their practices. Groups, for example, should generate a collective practice of problematization and discussion, provoking a growing learning process in all participants, including the professionals involved. With this, there is more active participation by the individual in the educational process and the involvement of the team of professionals with the community (Menezes; Avelino, 2016).

Blame also emerges in this profile, but we can already see that this group has a broader view of dentistry, addressing different issues that are not restricted to oral health, unlike the passive professional profile:

> With pregnant women, we talk about immunization, breastfeeding and nutrition. Issues that go far beyond the mouth. They don't just see us as dentists, they really believe that we can give opinions on other things. So we get away from just talking about oral health." (E8)

Progress has been made in redirecting these practices, through the realization that the mouth is not isolated, but within a body, which is the result of the biological, psychic and affective, broadening the view of these actions from the perspective of integrality (Merhy; Franco, 2003).

During the interviews, the professionals in this profile were more motivated in relation to their work process, which was also reflected in their educational practices and in their "effort" to carry them out, even in the face of some difficulties, which differs greatly from the passive professional profile. In addition, these professionals were almost unanimous in their opinion that there was a need to improve the types of educational approach in their practices, showing that these dentists are aiming to modify their health education actions.

The principles of dialog and the shared construction of knowledge were evident in the discourse of some professionals:

> We carried out actions according to the demands of the community. We tried to see, we tried to talk to the population, to see what they wanted and we started to do an activity according to what they demanded. (E6)

> In the pregnant women's group, we would ask them to give their opinion and what they thought would be good to address. We also saw some needs and made referrals based on what we observed. But we had this constant dialog with them." (E22)

Dialogue is considered to be a meeting of knowledge, in which there is respectful sharing of diverse knowledge, broadening critical knowledge and contributing to the process of autonomy and emancipation of the subjects. In this way, community participation and involvement are only possible through a dialog that allows for unity, development and awareness, in other words, education for social transformation (Nuto *et al*., 2006; Fittipaldi; O'Dwyer; Henriques, 2021).

It's important to reflect that if there is a relationship of trust and dialog between the subjects, there will be acceptance of the educational proposal, even if this proposal doesn't imply an immediate "gain" for the population involved. Coexistence and respect for differences sometimes become as important as, or even more important than, technical information when developing educational activities with grassroots groups (Acioli, 2008). In addition, listening, observation and interaction between people are fundamental in the communication process, and the worker's internal availability is essential, based on intentional action, guided by a concrete interest (Alves; Aerts, 2011).

The construction of knowledge refers to a process of interaction in which people with different types of knowledge come together based on common interests. Implementing this type of proposal presupposes incorporating the knowledge produced by the subjects involved into educational practices, valuing the exchange of experiences and knowledge between health professionals and the population, as well as proposing the incorporation of participatory planning into educational practices, which is already beginning to be observed in the statements of this group (Vasconcelos, 2001).

It can be seen that the hard-working dentists have already made some progress in the dialogic relationship and in the shared construction of knowledge in the educational process. However, other principles of EPS, such as problematization,

amorousness and emancipation, are still incipient, as is the use of more active educational methodologies in Health Education actions. There is also little evidence of this professional profile planning actions in a dynamic way, developed from observing the reality, interests and needs identified by the population, based on their social context.

Empowered dentists and the principles of EPS

In this profile, the professionals were more helpful and communicative, showing a critical view of the importance of their role in building the population's autonomy, based on the political/social context in which it is inserted, which was present in a third of the interviewees. They were identified as planning and carrying out educational activities in social spaces in the territory, using problem-solving approaches and exchanging knowledge. In addition, the discourse of these professionals reveals their commitment and motivation in educational activities, even though they are highly critical of the way services are organized and the biomedical model that still prevails.

With regard to the term "popular education", there is a sense of empowerment among these interviewees in relation to this concept:

> In popular education, we should always take advantage of the population's knowledge and add it to our more technical knowledge. So I think it's about us getting together with the community and trying to do education together. That Paulo Freirean thing, where you take advantage of what the population already knows, already does. (E1)

> Popular health education is the participation of the community within its own territory. It's the exchange, it's the discussion of strategies between professionals and the community itself. [...] It's the community being active in the educational process." (E20)

Of the 13 dentists in this profile, 11 have taken courses in popular education, which seems to have a direct impact on their discourse, on the way in which they are involved in the educational process and on the approaches they take in their practices.

> The best way to learn is to try to link something to what you already know. So our conversation circles were based on them bringing their knowledge first, and we were able to have a clear dialog with them. Their popular knowledge adds a lot to us [...]. Then there's also the story of the benzedeiras, which is a situation we respect and have as a very important ally in these actions. (E11)

> We assume that there is a process that we can bring to problematization, right? Paulo Freire's. It would be trying to bring a bit more knowledge to them by making some kind of reflections on these actions. (E15)

Dialogue, critical reflection (problematization) and the shared construction of knowledge, clearly seen in these statements, converge and represent tools that foster the encounter between popular and scientific culture.

EPS has built its uniqueness on opposing authoritarian knowledge and practices that are distant from social reality and guided by a medicalizing culture imposed on the population. However, it does not oppose, nor does it aspire to override scientific knowledge, but rather to act in a shared and dialogical way with the professional health practices established in the SUS, carrying a vision of different knowledge and practices that coexist in situations of reciprocity and cooperation (Oliveira *et al*., 2014).

The way of doing health that has traditionally been accumulated in popular forms of care, known as popular care *practices,* has revealed possibilities for building dialogued, participatory care processes that embrace popular knowledge. Some examples of popular care practices and their actors, some of whom have even been mentioned in this profile, are the raizeiros, benzedores, curandeiros, midwives, practices of African matrix terreiros, among others. It is therefore essential to take the knowledge of the popular classes as the starting point for the pedagogical process, promoting a process of horizontal debate and respect for popular culture, but with questions that make it possible to demystify it (Marteleto, 2009).

It is important to reflect that if there is a relationship of trust and dialog between the subjects, there is acceptance of the educational proposal, even if this proposal does not imply an immediate "gain" for the population involved. Coexistence and respect for differences sometimes become as important, if not more important, than technical information in the development of educational activities with grassroots groups (Vasconcelos, 2001).

The broadening of the view of reality based on action-reflection-action and the development of a critical conscience that arises from problematization allows men and women to perceive themselves as historical subjects, configuring a humanizing, conscientizing and protagonist process, as observed in this interviewee's speech:

> If you look for an identity with that audience, if you use mechanisms that can stir people's thinking, generate questions, if you use good didactics, education flows. You have to have an exchange. You have to generate reflection. (E9)

The shared construction of knowledge as an EPS principle guides educational practices in search of interdisciplinarity, autonomy and citizenship. In other words, practices that favor communicational interaction where subjects who hold

different types of knowledge take ownership of them, transforming themselves and transforming them (Oliveira *et al*., 2014).

It is in the articulation and constant dialog between the various types of knowledge that new knowledge can be created, a third type of knowledge, which represents the union and horizontality between scientific and popular knowledge. It is therefore a dynamic and continuous process that requires health professionals to have the broadest possible understanding of the world around the people and groups that express this knowledge (Marteleto, 2009).

> This logic of working on a more active education, especially listening to what they have to say and commenting on the acquired knowledge they already have, makes all the difference in these actions. Educational action must be built together with the population. (E15)

The principle of amorousness was widely perceived by the interviewees in this profile, and appears to be a key element in bringing the health service and the population closer together and building bonds with users, as it allows for the expansion of dialog in care relationships and in educational action through the incorporation of emotional exchanges and sensitivity. In this way, affection becomes a structuring element in the search for health.

> I notice the participation, the recognition and the bond that I form with this user [...]. There is this interaction between the community and me, as a health professional. We see the trust, the friendship that the community has with us. (E5)

> I ask how they're feeling, how their relationship with their family is. I try to see that person as a whole. You have to have empathy and love for what you do. And even with the difficulties, I feel very fulfilled with this job." (E10)

Loving kindness is an important dimension in overcoming dehumanizing practices and creating new meanings and motivations for educational practices. In addition, it brings a new meaning to health care, strengthening innovative processes already under construction in the SUS such as humanization, welcoming, social participation and tackling health inequities (Prado *et al*., 2011).

The construction of the Democratic and Popular Project encourages that educational and care acts, involved with EPS, must be committed to transformation, to overcoming injustices, to overcoming health inequities and social inequality, as seen in this interviewee's speech:

> I see that this community is very rich culturally. Many people have a historical culture because this is a neighborhood that grew out of a struggle. [...] and here they have a lot of

> political awareness. This health unit exists because of a popular struggle. And we should use this potential in these practices." (E30)

It can be seen that the "potential for struggle" is used as a way of confronting the problems of reality in that reality, so that educational actions don't just focus on the transmission of knowledge, but that the health team and the community are able to build a rich and dynamic project of struggle and overcoming, giving a voice to popular subjects and social movements.

In line with this, emancipation is seen as a collective and shared process of people's conquest and liberation from all forms of oppression, discrimination and violence that still exist in society and that produce dehumanization and the social determination of illness (Brasil, 2013).

> Sometimes you're talking, giving advice, and you don't know the reality of that family. How can you change a reality that you don't know? We need to be close to people's way of life, so that we can propose a change in that reality. [...]. We have to be aware that health is not just the absence of disease. There are many other factors involved. Domestic violence, hunger, lack of adequate housing, all of this creates vulnerability. (E9).

Emancipation linked to educational practice promotes the strengthening of the sense of collectivity in the perspective of a just and democratic society, in which people and groups are protagonists through reflection, dialog, the expression of love, creativity and autonomy, affirming that liberation only happens in the relationship with the other (Pinheiro; Bittar, 2016).

It is notable that in the interventions mediated by EPS, there was greater autonomy, protagonism and community participation, confirming the potential of this methodology to favor user participation and dialogue between scientific and popular knowledge.

The municipality of Fortaleza-CE has a significant history of actions and training processes in EPS, such as the experiences of Cirandas da Vida, Espaço Ekobé and editions of the EdPopSUS course. Despite the influence exerted by these experiences on some professionals of this profile, it can be seen that the municipal management has distanced itself from these movements:

> In the past, this issue of permanent education and popular education was highly valued. We had the Cirandas, we had an exchange, we had a greater exchange of popular knowledge with ours. They coexisted. Then, when management changed, the logic of care changed a lot. (E11)

This study showed that even with the perception of the importance of educational action in the context of health promotion, there is little investment in a Permanent Education policy that seeks to disseminate EPS knowledge as a strategy for redirecting professional educational practices.

Observing that the majority of empowered dentists have taken some course or training related to popular education, it is clear that transformative educational practices are not built intuitively, but through a continuous and dynamic process of knowledge and reflection in which health professionals need to be immersed. In this way, the use of EPS principles in oral health practices becomes an instrument for reorienting educational practices, stimulating the population's critical awareness and autonomy in relation to individual and collective health decisions.

Conclusions

Based on the testimonies analyzed, this study shows the existence of three professional profiles, the passive, the hard-working and the empowered, who even though they are subject to the same economic and social situation, working in the same context and in the same municipality, carry out and perceive their educational activities in completely different ways.

Even with the selection of an intentional sample, in which UAPS with a history of good educational practices were selected, and the perception of the strong presence of EPS principles in the actions of empowered professionals, knowledge, exercise, reflection and experience of these principles by dentists of the other profiles are necessary. In addition, it is of the utmost importance to consolidate PHE in the practices of these professionals, as a strategic resource that enhances the population's awareness of their living conditions and reinforces popular organization and social struggles for health.

This highlights a challenge still present in Health Education actions, demonstrating the need to create a new hegemony represented by professionals guided by EPS and respect for community knowledge. In order to do this, they need to be included in a dynamic and continuous Permanent Education process, one possibility being the use of EPS itself as an educational proposal in the training and qualification of these professionals, not just as a working method, but as a trigger for reflection on their practices.[1]

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Note

[1] L. F. Amarante: conception, design, analysis and interpretation of the data; writing of the article and relevant critical review of the intellectual content; final approval of the version to be published; responsible for all aspects of the work in ensuring the accuracy and integrity of any part of the work. S. de A. S. Nuto and F. D. S. Forte: analysis and interpretation of the data; relevant critical review of the intellectual content; final approval of the version to be published; responsible for all aspects of the work in ensuring the accuracy and integrity of any part of the work.

Resumo

Educação Popular na saúde bucal: análise de práticas educativas na Atenção Primária

A Educação Popular em Saúde emerge como norteadora de práticas educativas na Atenção Primária, tornando-as mais dialógicas e em sintonia com a cultura popular, sendo embasada por princípios contidos na Política Nacional de Educação Popular em Saúde. Este estudo analisa as práticas educativas de cirurgiões-dentistas na Atenção Primária, buscando identificar os princípios da Educação Popular em Saúde nessas práticas. Os dados foram coletados através de entrevista semiestruturada com 39 cirurgiões-dentistas do município de Fortaleza-CE, em que foram identificados três corpus de análise baseados em três perfis profissionais evidenciados: passivo, esforçado e empoderado. Nos dentistas passivos não foram identificados princípios da Educação Popular em Saúde. Já nos esforçados, apenas os princípios do díalogo e da construção compartilhada do conhecimento foram evidenciados. No perfil empoderado, foram identificados todos os princípios, sendo perceptíveis o uso e o conhecimento da Educação Popular no cotidiano desses profissionais. Conclui-se que ainda há a necessidade de intensificar e direcionar o processo de Educação Permanente dos profissionais utilizando a Educação Popular como norteadora, possibilitando ações educativas mais dialógicas e problematizadoras junto à comunidade.

➤ **Palavras-chave:** Educação em Saúde. Educação em Saúde Bucal. Atenção Primária à Saúde.