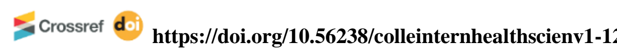
Chapter 123

Historical Aspects Of Health Campaigns In Brazil: Proposing An Education In Health Sciences Through Popular Education

 https://doi.org/10.56238/colleinternhealthscienv1-123

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ABSTRACT
In Brazil, the embryo of what is known today as "Health Education" appears only in the second half of the 19th century, after the arrival of the Portuguese royal family. Despite this, health campaigns, defined as advertisements that aim to guide the execution of self-care practices, therefore essential instruments of Health Education, appeared only in the early twentieth century, based on a coercive and controlling model. Over the decades, the use of health campaigns as instruments of Health Education has had its objectives, target audience, and performance spaces modified. Thus, the way this type of campaign is run today is the result of a historical process that is intertwined with the health and education models advocated in each period of Brazilian history. Nowadays, a more dialogic and inclusive model of Health Education is advocated, called Popular Education in Health, and it is necessary to apply this model to the instruments that make up the health campaigns. Given this, it became evident the need to reflect on the use, production, and messages conveyed in health campaigns in order to understand the need for this material to actually move towards an Education in Health Sciences through Popular Education.

Keywords: Health Education Printed Materials, Popular Health Education, Health Campaigns.

1 INTRODUCTORY REMARKS

Sanitary Campaigns are those that guide towards the care of one's own health rather than encouraging consumption (ROCHA and FELTES, 2016), and are based on a health model of the early twentieth century, called "Sanitarista Campanhista" (COSTA and CARNEIRO-LEÃO, 2021).

Since then, the functions of health campaigns in the health education process have changed, including having some of their printed materials used in the formal school environment from the understanding that the teacher should also play the role of "health educator subject", besides the rest of the population (SILVA, C. et al., 2010).

From a legal point of view, the PCNEM+ (Parâmetros Curriculares Nacionais do Ensino Médio Mais) for the area of Natural Sciences (BRASIL, 2002), ratifies the need to work with several types of informative and media texts in the school process, corroborating the understanding of the teacher as an educator of health campaigns in the classroom.

Thus, health campaigns have become increasingly frequent in the educational environment, especially those aimed at combating epidemic and/or endemic diseases that have living organisms as

vectors, especially dipterous[1] , which can enter almost imperceptibly in the lives of virtually all citizens, due to their size and mobility. In this sense, it is necessary to reflect on the historical process of health campaigns linked to Health Education and the very concept of health in Brazil, especially because "the relationship between education, health and its practices is conditioned by complex structural dimensions that need a historical analysis for its greater understanding. " (SILVA, 2010, p. 2540).

Moreover, in the conception of Maciel (2009), the concepts and objectives of Health Education, over time, were equally influenced by modifications in the pedagogical processes of teaching and learning in formal school education.

Despite the changes, health campaigns have always been present, permeating the various conceptions of health and offering subsidies for promoting and/or fighting diseases; thus, it ends up strengthening the need for a link between health campaigns and the history of Health Education. Thus, entering the historical meanderings of health campaigns and understanding their establishment process and characteristics implies discussing the history of Health Education in Brazil.

This point is reinforced by the words of Silva, C. *et al.* (2010), when claiming that

> In the historical plan, the succession of education models applied to the public health area does not mean an evolutionary sequence; rather, it is a description of the dominant practice in certain periods in relation to the health problems highlighted for intervention, aiming at the maintenance of the dominant class hegemony. (p. 2540).

That is, the historical analysis cannot be made in a perspective of progressive modification of the Health Education models, but rather in the sense of correlating each model to the historical context, aiming to understand its complexity, especially if we consider that some methods, such as health campaigns, have always been present, with only the form of their applicability changing. This is what we will try to do in our next topic.

2 HISTORY OF HEALTH CAMPAIGNS AS INSTRUMENTS OF HEALTH EDUCATION IN BRAZIL

Only in the 19th century, due to the Portuguese royal family's move to Brazil in 1808, hygienic pedagogies began to be thought of for Colonial Brazil with the purpose of educating the elite families (SILVA *et al.*, 2010), through the foundation, by Dom João VI, of the Medical-Surgical College at the Royal Military Hospital of the City of Salvador, Bahia; and through the creation, in November of the same year, of the School of Surgery of Rio de Janeiro, attached to the Royal Military Hospital (POLIGNANO, 2001).

Given the State's lack of concern for health issues, and the poor sanitary and socioeconomic conditions in which the population lived, epidemics of plague, yellow fever and smallpox began in Brazilian

[1] It is an order of organisms belonging to the class Insecta, phylum Arthropoda, and Kingdom Animalia, in which flies and mosquitoes in general are included.

territory in the late nineteenth century and early twentieth century (MACIEL, 2009; PELICIONI and PELICIONI, 2007; SILVA *et al.*, 2010). In this context, the State was forced to systematically intervene in models of Health Education extended to the popular classes, aiming to combat the evasion of merchant ships from Brazilian ports, which harmed the agrarian-export model of the time (MACIEL, 2009; SILVA *et al.,* 2010).

However, this expanded model of Health Education, called "Health Education" (MACIEL, 2009, p. 774), was coercive to the working classes, who found a tormentor in the so-called "health police", created to curb, monitor and maintain the welfare, disregarding the relationship between disease and environment. In this period, the ignorance of the people was taken as the cause of epidemics of the time (SILVA *et al.*, 2010). Thus, the expansion process did not aim to persuade or sensitize, but rather inhibit practices considered as "harmful", characterizing health and well-being as a duty rather than a right.

Moreover, according to Galvão (2009), this model aimed only to combat epidemic diseases that attacked indiscriminately the various social classes. The author cites the example of tuberculosis, which was a real problem in unhealthy sectors of society. However, since the high mortality rate did not affect the elites, the disease was not considered a problem by the Brazilian State of the time.

Silva *et al.* (2010) also point out that in the period between the late nineteenth century and early twentieth century the so-called "advice to the people" (p. 2541) were distributed to the population, which were loose leaflets on ways to avoid diseases, constituting marginal educational practices. The authors point out that the goal was not to educate the population, but to use the discourse that instruments of persuasion had been used before the State was "forced" to act in a coercive way. This model, officially implemented at the national level by Oswaldo Cruz in 1902, became known as "sanitarismo campanhista" (POLIGNANO, 2001), whose main role of the educator (imbued to the sanitary police, according to chart 1) was to control and supervise the population.

This "campanhismo" of Cruz can be considered a landmark for the implementation of campaigns to combat disease in Brazil. However, due to the historical characteristics of the time, the campaigns against yellow fever, in 1903, and against bubonic plague, in 1904, often consisted of home invasions for extermination of biological vectors, destruction of collective housing buildings, requirement of costly architectural modifications in housing, forced hospitalizations and interdictions (GALVÃO, 2009; MACIEL, 2009). In other words, the health campaigns implemented by Cruz did not aim to persuade the population, but to precede the action of the health police, as shown in Table 1, which caused broad discontent in the popular classes.

The last and most widely known campaign executed by Oswaldo Cruz in Brazil with this model was the vaccination against smallpox, executed after the enactment of a law in November 1904, which made the vaccine mandatory throughout the national territory (MACIEL, 2009; SILVA *et al.,* 2010). The law caused widespread revolt of various sectors of society, leading to the known Revolta da Vacina.

It is clear that education/awareness raising was not the goal of the health campaigns implemented in this period, as Pelicioni and Pelicioni (2007) have already concluded. The participation of education professionals in the campaigns, as well as a process that aimed to educate/awaken the civil society with more dialogue from the political forces could have enabled more successful investments for the popular strata in the period.

Although the publication of Euclides da Cunha's book *"Os Sertões" (The Hinterlands)* in 1902 caused widespread indignation in Brazilian intellectual circles, due to the report of misery and disregard for the Northeastern Sertão (backlands) that the work brought, it was only in 1918, when Monteiro Lobato publishes his book of short stories *"Urupês"*, the situation of disregard for the health of the countryside gains repercussion, deconstructing the profile of the lazy "caipira" who does nothing to change his reality (SILVA *et al.*, 2010).

Falkenberg *et al.* (2014) point out that the reason for the repercussion of Lobato's work at the time was the character Jeca Tatu, who was a rural worker from Vale do Paraíba - SP, who suffered from hookworm disease. The character served to denounce the precarious living conditions of the population in relation, above all, to the lack of health care.

Thus, the character of Jeca Tatu served to show that the Brazilian backwoods problem was not associated with race, but with the diseases that affected the population, making them lazy and without initiative (SILVA, C. *et al.,* 2010).

Moreover, at the time it was common, as reported by Falkenberg *et al.* (2014), that health campaigns used the figure of Jeca Tatu "indicating that the origins of health problems were of individual responsibility, not contextualizing health problems critically from collective changes. " (p. 849), serving only to reinforce the campanista sanitarist model, without presenting fruitful educational initiatives.

Only in the 1920s, when Carlos Chagas restructured the National Department of Public Health (DNSP), was there a space offered to educators in Health Education (chart 1), with the task of disseminating and convincing the Brazilian population to adopt certain behavioral patterns considered ideal for health maintenance.

At this time, a "health education" is formally designated and, according to Polignano (2001), propaganda begins to constitute the routine action practices of the DNSP, and this is the first time in Brazilian history that Prevention takes a prominent place in Health Education processes and health campaigns.

According to Silva *et al.* (2010, p. 2542), the structure of health education that came into force from 1920 "removed the authority of health police and health education actions were developed by health educators and teachers, who were trained to exercise the function of educating the school population". Thus, it is possible to observe that the revolts (both popular and literary) and the change of direction of the DNSP caused a primary structuring of what would be called Health Education in the following decades, with a greater focus on persuasion and less on coercion.

However, according to Vasconcellos (2001), the actions of these educators still consisted in the normative imposition of behaviors considered by the elites as adequate for health promotion. That is, at this time the model of Health Education, recurrent in the 1900s, which the author called "toca boiada" (p. 123), was maintained.

However, in Vasconcelos' (2001) conception, there is a difference between the model of "toca boiada" adopted in 1900 and that of 1920: if with Cruz the driving of the herd (general public) was done exclusively by means of the sting (fear and threat); with Chagas, the berrante (the educator's word subsidized by the health campaign pieces) was also considered an essential instrument.

Board 1 - Systematization on the trajectory of Health Education in Brazil and the role of health campaigns in different periods.

COMPONENTS	UP TO 1920'S	1920'S	1950'S	1960S AND 1970S	FROM THE 1980S ON
Designation of health educational practices	Not configured.	Health education.	Health Education.	Public Health Education or Health Education.	Health Education and Education Popular Health.
Event(s) that influenced the applied methodology in such practices	Flexner Report. Pasteur's Bacteriology.	First Brazilian health reform. Creation of the Ministry of Education and Public Health	The FSESP Foundation (Foundation of Special Public Health Services) arrives in Brazil and the Ministry of Health is created	Military coup in Brazil, Alma-Ata Conference and community medicine projects.	VIII National Health Conference and the Citizen Constitution.
Place or spaces of act	Residences and public places.	Health centers, schools, and nursing homes.	Schools, workplaces, and rural communities.	Health services and schools.	UBS (Basic Health Unit), schools and spaces community.
Target Population	Urban elite.	Families and school.	Urban and rural population of all ages.	Schools and specific groups.	The entire population.
Who was the educator	Health Police.	Health educator and teachers.	Health educator and health professionals.	Health teams multiprofessional.	Everyone involved, including the population.
Attributions of the educator	Supervision.	Spreading medical knowledge and convincing the lower classes to follow patterns of behavior.	Social intervention practices to modify social behavior and generate cultural change.	Empower the learner for self-care.	To seek, together with the population, proposals for solutions to health problems.
Role of the educator	Controller.	Disseminator and communicator.	Intervenor.	Coach.	Mediator.
Activities developed by the professionals at health education	Health advertising and Inspection health.	Lectures, conferences and production of printed matter.	Group education and teamwork. Encouraging community participation to fill government shortfalls.	Methodology centered on the educator or professional, who passes information about self-care to the population.	Traditional education is still hegemonic, but participatory methodology is gaining space in universities and health policies.
Role of health campaigns	Anticipate the action of the health police.	Main vehicle of information	It is just another information vehicle	Inform set of standards.	Mediate educator-student relationships.

Source: Silva, C. *et al.* (2010) with author's adaptations.

A breakthrough to be noted in this period concerns the opening of Rural Prophylaxis Posts (PPR), in the interior of more than eleven states, which centralized the actions of Health Education and institutionalized these practices (GALVÃO, 2009).

Despite recognizing these advances, Silva *et al.* (2010) point out that, although there is the diffusion of PPRs within the country, the main focus of the then "Health Education" was children and adolescents, especially because the period coincides with the so-called "New School", which assigned to the learner the focus of the teaching and learning process. The authors also emphasize that the sensitization process in this Health Education model was supported by the positivist ideary, since the educators were trained to repeat the same speeches and use the same propagandistic materials wherever they were, which kept them away from the subjects to be educated. With that, this model is still consolidated much more as a punch-lifter, hindering the teaching and learning process in Health Education.

In the 1930s, the Vargas Era was characterized, according to Maciel (2009), by the construction of Health Centers whose goal was to spread notions of health and individual hygiene. This model aimed to overcome its predecessor, which gave much importance to etiological agents and almost none to environmental factors that could trigger diseases (SILVA *et al.*, 2010).

In order to intensify the fight against infectious and parasitic diseases, "health educational actions are restricted to programs and services for populations at the margins of the central political game" (VASCONCELOS, 2015, p. 26), thus, health campaigns at this time were focused on the most popular classes and special programs, such as maternal and child health and emergency care (SILVA *et al.*, 2010). Thus, health campaigns had the role of communicating ways to prevent diseases, reviving the campanista sanitarian model in the 1920s.

In the 1950s, according to chart 1, the so-called "Sanitary Education" gives way to an "Education for Health", which has as its main landmark the creation of the FSESP (Special Public Health Service Foundation), constituting a propeller for the advances in Brazilian health institutions, since it brought new prevention technologies to Brazil.

Moreover, the model of "Developmental Sanitarism" (PELICIONI and PELICIONI, 2007) began, which had as one of its main mentors the sanitary doctor Mário Magalhães da Silveira. In the conception of Escorel (2015), this new model associates development to health, emerging as a criticism to Sanitarismo Campanhista and favoring fruitful environments for experiences that would provide social development.

Thus, to achieve success in health and Health Education policies it was necessary to develop Brazil and its population, from the economic and social point of view, breaking with the idea that only a portion of the population could be educated. Moreover, the concept of self-sufficiency of health campaigns to solve the problems of epidemics is also abandoned. That is, in this period the health campaigns lost the majority position of communication with the population.

From this, another aspect to be highlighted arises: a proposal for popular participation in health, which, according to Silva *et al.* (2010), arises to try to channel and mobilize the population's energy to overcome the marginality in which certain portions of society found themselves in this period.

With the new model, methodological teaching and learning innovations incorporated into Health Education appear, such as: "group education, the audiovisual resources and the development and organization of communities, triggering ideas of participation and mobilization of individuals in health actions, countering the centralizing and paternalistic policy of the State as a whole. " (SILVA *et al.*, 2010, p. 2544).

Polignano (2001) emphasizes that this period was marked by: shortage of financial resources and personnel among various agencies and sectors created for health promotion and supervision; conflicts of jurisdiction and management between the Union, States and Municipalities; and overlapping functions and activities of some agencies. Still according to the author, all these obstacles "meant that most public health actions in the State [...] were reduced to mere normative aspects, without effective solutions in the practical field for the major health problems existing in the country at that time. " (p.12).

Thus, it is possible that the process of inviting popular participation has occurred not out of interest in providing the population with a captive seat in the deliberations on the then called Health Education, but rather to use popular labor in what the state was inefficient: promoting health. This understanding is strengthened by Silva *et al.* (2010), when the authors state that although this period is marked by the expansion of physical spaces of services, training of various health volunteers and community participation programs for sanitation works, the medicine used was of simplistic nature and did not contribute to reducing the cultural and social gap for the popular layers to whom it was intended.

Valla (2006) criticizes this "popular participation model". In this author's conception, the process of popular participation is only effective if it confers decision-making power and political participation to organized civil society entities in institutions, agencies, services and/or state organs that operate in social policies, giving these entities the opportunity to dispute the control and destination of public funds.

However, for Silva *et al.* (2010), it is necessary to point out that, although the conception of popular participation was manipulated by the State in this period, Health Education started to be offered to the entire population. Now, not only children and adolescents were considered the only ones capable of being educated, and a seed of what would become Popular Health Education was planted.

In 1964, Brazil suffered a military coup, which resulted in the worsening of health services for the poorest layers of the population (SILVA *et al.,* 2010), causing the resurgence of some diseases, such as tuberculosis, malaria and Chagas disease (MACIEL, 2009). In addition, the health policy of this time went through a system of advancement of private health services, notably hospitals, which became responsible for health care (PELICIONI and PELICIONI, 2007; VASCONCELOS, 2015) and in which educational practices had no space (VASCONCELOS, 2015). With this, the popular layers of the country were forced

to coexist with infectious diseases, with the physical suffering caused by them and without access to efficient public health policies.

From then on, a purely technocratic logic emerges from the groups of educators (in this period composed of multi-professionals) who worked in the then called "Health Education", assuming an understanding that it was up to them to train the student (table 1) for self-care (SILVA *et al.,* 2010) - A purely transmissional and positivist logic, similar to that adopted in the 1920s. In this sense, health campaigns now existed as a set of rules to be followed.

From the 1970s on, the Brazilian State faced the possibility of a break in social stability, being forced to be more attentive to the population's social problems, among them health (POLIGNANO, 2001). From this decade on, Health Education becomes mandatory in high school and elementary schools[2] , according to article 7 of law number 5.692/71, "with the purpose of stimulating the knowledge and practice of basic health and hygiene in students" (SILVA *et al.*, 2010, p. 2545).

In this decade, SUCAM (Superintendence of Public Health Campaigns) was also created, whose main attribution was to execute activities leading to the eradication and control of endemics, especially the malaria eradication campaign (POLIGNANO, 2001).

Despite this, several popular movements erupted throughout the country (PELICIONI and PELICIONI, 2007), encouraging health specialists, indignant with the model applied by the military regime, to develop work focused on the dynamics of the reality of the most popular classes (FALKENBERG *et al.*, 2014; MACIEL, 2009; VASCONCELOS, 2015).

According to Vasconcelos (2001; 2015), this movement innovated the culture in the Brazilian Health sector on two intrinsically related fronts: first, it implemented the construction of knowledge exchange relationships between health educators and popular communities, deconstructing the positivist transmissional logic present in the health campaigns of the time; and second, as a consequence of the first, it broke with the authoritarian and normative dynamics of Health Education.

Thus, despite the authoritarian environment, there was a favorable space for the emergence of reflections among various sectors of society, especially experts trapped in the universities, to build a health system that would meet the needs of the population. Based on this understanding, the following began to be:

> introduced in Brazil the principles of primary health care, based on the recommendations of the Alma-Ata Conference (ROCHA, 1997), giving a new direction to health policies, emphasizing community participation, cooperation between different sectors of society and primary health care in its conceptual foundations (OLIVEIRA, 1997; ROCHA, 2003). (SILVA, C. *et al.*, 2010, p. 2545).

[2] In this period these school phases were called, respectively, first grade and second grade; we have opted to adopt the current nomenclature in the body of the text.

For Pelicioni and Pelicioni (2007), although the military dictatorship was only ended in 1985, these movements constitute the beginning of the redemocratization of Brazil, especially regarding the participation of civil society in health policies in the country.

Falkenberg *et al.* (2014) and Vasconcelos (2015) point out that one of the main influencers of the educational modifications that were about to happen was the educator Paulo Freire, who in his experiences advocated the need for a less verticalized and much more dialogical education, to which the educator and researcher called Popular Education. These conceptions directly influenced Health Education.

The experiences of Health Education with popular participation begin to be more recurrent, being called from the 1980s on, according to chart 1, "Popular Education in Health" (MACIEL, 2009), acting in rural areas and urban peripheries along with the so-called "Community Medicine"[3] (SILVA, *et al.,* 2010).

It is important to point out that:

> popular health education has a different conception from the hegemonic health education, [because it] organizes itself from the approximation with other subjects in the community space, favoring local social movements, in an understanding of health as a social and global practice and having as ethical-political beacon the interests of the popular classes. It is based on the dialogue with the health service users' previous knowledge, their "popular" knowledge, and on the critical analysis of reality (FALKENBERG *et al.*, 2014, p. 849).

That is, the idea of Popular Health Education arises from the need to build a link between technical-scientific education and popular knowledge, considering the popular layers as holders of knowledge about their reality that Health Educators should understand. From that, the goal now is not to form polished citizens who act according to a set of predetermined norms, but to help the popular layers in the conquest of their autonomy and their rights (MACIEL, 2009), being health one of them and health campaigns an instrument of mediation between the educator subject and the educated subjects.

Currently, both "Health Education" and "Popular Health Education" are terms commonly used in Brazil to describe educational practices in health. However, for Falkenberg *et al.* (2014), although both practices have similar theoretical assumptions of dialogic interaction between professionals, managers, and the population, constituting a space that serves for reflection and individual and collective autonomy, Health Education practices commonly abandon these assumptions completely.

According to Vasconcelos (2017), this justifies the dialogic reinforcement that Popular Health Education has to offer in Health Education practices, since nowadays a model that breaks with the understanding that popular classes are "tabula rasas" devoid of knowledge is fundamental, but rather

> [...] composed of people and groups with an intense "quest to be more" (an expression often used by Paulo Freire), with significant and surprising knowledge about how to seek joy and health in their concrete conditions of existence and with great creativity to participate in the construction of solutions to their problems. (VASCONCELOS, 2017, p. 21).

[3]For Vidal (1975, p. 11), community medicine would be "the set of intra and extra-hospital actions of integrated medicine that form a health team with the active participation of the community.

However, according to Valla (2006), the official documents of the federation, states and municipalities usually adopt a diffuse tone regarding what would be popular participation in Health Education. In the author's perspective, Brazilian governments still act in a very authoritarian way with the popular classes, unilaterally deciding which public health problems deserve attention, the degree of investment in each epidemic and, consequently, the tone of health campaigns, which end up calling for the participation of the community in the process of eradication of a certain "evil" (epidemic on the rise), through a **joint effort**[4] . That is, in the official documents, popular participation in Health Education is restricted to actions predetermined by the State, as pointed out by the research of Costa and Carneiro-Leão (2020).

Silva *et al.* (2010) point out that the practice of a Mutirão, in the terms pointed out by Valla (2006), is completely different from the assumptions of Popular Education in Health, since it works only for the State to use free labor to perform tasks that are in its charge, in a very similar way to what happened in the 1950s.

Valla (2006) goes further when he argues that by calling on the population to exterminate a particular biological vector of a disease, through health campaigns, governments individualize the issue. That is, if the direct culprit for the disease is the biological vector, the indirect culprit would be the population that did not perform the set of actions requested in the campaigns. This is known as "**victim-blaming**, a practice that allows one to hide the malfunctioning of public services and the lack of commitment from governments. "(VALLA, 2006, p. 53, our emphasis), which continues to be increasingly common in health campaigns in the 21st century.

In this sense, the demarcation of Popular Health Education's territory, in the sense of strengthening its assumptions and putting an end to pseudo-practices that claim to be popular, is much more than necessary, extending this duty to health campaigns, which should be an instrument of this Health Education model.

This concern is reinforced when we remember that many of these campaigns can be used by teachers, taken by students or even indicated by agencies linked to Federal, State and/or Municipal Governments (Secretaries/Ministries of Education, Health, Environment, among others) as sources of information. Walking in this direction, Almeida-Júnior (2000) attends to the fact that we must consider these visual resources as informative discourses of society, since they can be responsible "for mechanisms of reitification[5] of the educating subject, [and] must be considered as an instituting model of realities" (p.19).

Charaudeau (2013) also points out that a sanitation campaign "aims to dissuade individuals, who live in society, from maintaining a behavior harmful to the collectivity, being necessary the adoption of

[4] For Valla (2006) examples of community work are the construction of health centers, school reforms, street cleaning, and other activities that would be a state obligation and that the population is invited to perform in government campaigns.
[5]Reification is a term used by the author Almeida-Júnior (2000) to designate the process of making a subject develop a set of socially acceptable behaviors.

another behavior" (p. 383). This conception is reinforced by Joly (1996), when the author stresses that advertising campaigns, of which sanitation campaigns are part, are certainly intentional, and aim to coax[6] the subject to adopt certain behaviors and practices.

Thus, it is necessary to consider health campaigns as instruments that can be used by the teacher during the mediation of the relationship between knowledge and student, in order to promote the so-called Popular Education in Health that enables the construction of the subject's autonomy through thinking about the models propagated in them.

This alert becomes even more forceful when we consider the communication models adopted in current health campaigns. The study developed by Freitas and Rezende-Filho (2011) sought to analyze in national scientific articles, through searches for key terms[7] in *Scielo* (*Scientific Electronic Library Online*), communication models of printed materials used as an educational strategy in health. Of the eleven articles found by the authors, nine contained health campaign printed materials that reinforce the model that the subject to be educated is only a consumer of the practices present therein.

Moreover, it is crucial to consider how these campaigns are used in Health Education. Research developed by Sales (2008) and Souza et al. (2003) indicate the importance that the health educator does not use a health campaign considering the subject being educated only as the "target audience", but understands him/her as the subject of knowledge and thus encourages this subject not only to apply the information in the materials, but also to promote changes in order to bring them closer to his/her daily life. In our understanding, the practice of encouraging the process of adaptation of these materials is a step to help break the transmissional logic pointed out as common in the study of Freitas and Rezende-Filho (2011).

Of course, these studies symbolize only a part of the whole range of health campaigns disseminated on the national scene, but they reveal a worrying trend of these instruments, strengthening the concern about the need for a Popular Health Education in the process of using and building this resource.

Despite this, it is necessary to determine the term "Health Education" as the majority one, especially due to the official recommendations of the Virtual Health Library (VHL), linked to the Brazilian Ministry of Health, according to Falkenberg *et al.* (2014). But it is necessary to emphasize the understanding that the usability of the term does not imply ignorance of the goals advocated by Popular Health Education, because, according to Vasconcelos (2015), Popular Education should be understood as a theoretical reference that should permeate Health Education, before being understood as an independent model. That is, the use of health campaigns, as educational tools, should be supported by the premises of dialogue between educator and student, providing opportunities for knowledge exchange and expansion of these materials to suit the realities in which they will be used.

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[6]According to Joly (1996), this would be an acronym between the words "coercion" and "seduction", which we adapted to a non-existent verbal form in the Portuguese language.

[7]The descriptor used in the initial search was "health education" combined with uniterms (didactic materials, educational materials, informative materials, printed materials, leaflets, posters, educational primers, and orientation manuals); in the second search, the descriptor "printed materials" was used, for a more precise search (FREITAS and REZENDE-FILHO, 2011).

However, to achieve this dialogue it is necessary to broaden the term to "Health Science Education". This defense happens for a basic set of reasons. First, although health-related themes are cross-cutting issues, it is up to the subjects of Science (in Brazilian elementary school[8]) and Biology (in Brazilian high school[9]) to discuss the theme in depth, according to the PCNEM+ (BRASIL, 2002; 2006).

Second, Health Education, in the context of basic education, is permeated by a group of biological scientific concepts, many of them present in the educational materials distributed by government agencies to work in Brazilian schools (MORAES and ANDRADE, 2009), which students need to understand and are sometimes relegated to the background, requiring Science Education to be as present as Health Education to promote the dialogue advocated above.

Last but not least, health education work, especially in poor communities, needs to be developed based on the understanding that the Science and Biology teacher, by discussing health-related issues in his or her classroom, is also a health promotion professional, who often uses biological scientific concepts to explain health and disease phenomena.

Based on this, we understand Health Science Education as a part of the whole that is Health Education, with the teacher as the major professional. Thus, it is crucial to consider that the Health Science Education professional who will use a health campaign does not consider the student only as the "target audience", but understands him/her as the subject of knowledge and thus encourage this subject not only to apply the materials but also to promote changes in order to bring them closer to their daily lives (SALES, 2008; SOUZA et al., 2003), breaking the transmissional logic commonly adopted (FREITAS and REZENDE-FILHO, 2011).

Therefore, it is necessary to consider that these campaigns are driven by diseases with higher incidence and prevalence in a given historical moment, being conventional to use some of them to ensure that the formative process is related to reality, as presupposed by the theoretical basis of Popular Health Education, which also subsidizes our Health Sciences Education. All these elements strengthen the importance of a horizontal dialogical relationship between student and health educator, promoting sensitization through scientific knowledge.

3 CONCLUDING REMARKS

The historical reflection process that we propose to carry out is not exhausted in this brief work. We believe that the discussions raised serve as an introduction to an important debate on the use of health campaigns in Health Education and, consequently, in Health Sciences Education. Nowadays, as pointed out in the text, Brazilian health campaigns still seem to follow a very transmissional model, and it is emergent to reflect on this kind of material, understanding it as part of the educational bulge.

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[8] Elementary school is one of the levels of basic education that is compulsory in Brazil. It lasts nine years and is mostly aimed at people between the ages of 6 and 14.

[9] High school is one of the levels of basic education, compulsory in Brazil. It lasts three years and is mostly aimed at people between 15 and 17 years old, preceding Brazilian higher education.

Popular Education in Health seems to show itself as a tool that can help combat the idea of "blaming the victim", present in the invitations to organize health campaigns and, therefore, result in a greater engagement of the population in fighting diseases. It is necessary to make health campaigns reach the outskirts in a different way than a rulebook, establishing, in these materials, opportunities for dialogue with society. Thus, we see in Health Sciences Education a strategy to propose a more horizontal and dialogic model of health promotion.

In this sense, there is a long way to go to research more deeply the use of health campaigns, both in formal and non-formal Health Education settings in Brazil, as well as to analyze and discuss ways to overcome the obstacles these materials face in reaching the general population.

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