Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

Notas preliminares sobre a Associação Brasileira de Ensino da Educação Física para a Saúde – ABENEFS

Silvio Aparecido Fonseca / Aldemir Smith Menezes / Wallacy Milton do Nascimento Feitosa / Mathias Roberto Loch

Palavras-chave: Educação Física; Treinamento; Ensino; História.
Keywords: physical education; training; education; history.

INTRODUCTION

In a recent and pleasant reception enjoyed by the Brazilian Association of Physical Education Teaching for Health (ABENEFS) at the National Forum on Education of Health Professions (FNEPAS), we were also handed the challenge of making a presentation to colleagues from other areas of health outlining the background, advances made and dilemmas of our profession. We believe this forum will support a more harmonious and fruitful relationship between physical education and other categories of health, in the different learning and practice settings, where we have met in recent years to share our knowledge and frustrations, in short, where we seek the alternative point of view for training and multiprofessional intervention in order to achieve comprehensive training and health care.

Thus, we aimed to introduce physical education in terms of who we are, what we do and what ABENEFS intends to undertake to strengthen the ties with teachers, students, professionals and subjects in order to learn and contribute to the transformation processes in multidisciplinary health training. There is no a priori concern in centering the narrative of the text on an exclusively pragmatic or scientific historical basis. These factors naturally delimit one another, in virtue of our own restrictions in terms of space, knowledge and the matter at hand.

With this understanding, we hope you enjoy reading and reviewing the essay, and we would like to make it clear that our opinions do not necessarily represent the same ideals of the whole physical education profession, although the proposal has been well received by leading researchers into training in our field and in health. The text is nothing more than an effort by academics of a young profession, aware that doctrines of the Sanitary Reform Movement and the care that the population long for, must be related to high quality multiprofessional training in health.

---

1 Santa Cruz State University/Department of Health Sciences, Federal University of Santa Catarina/Sports Centre/Physical Education Graduate Program.
2 Federal Institute of Education, Science and Technology of Sergipe; Federal University of Santa Catarina/Sports Centre/Physical Education Graduate Program.
3 Caruaruense Association of Higher Education; Aggeu Magalhães Research Centre/Fiocruz/Public Health Graduate Program.
4 State University of Londrina/Department of Physical Education; State University of Londrina/Collective Health Graduate Program.
HISTORY OF PHYSICAL EDUCATION:
BRIEF OVERVIEW

Training in Physical Education in Brazil began under the auspices of the Royal Military Academy. Back in the imperial period, Opinion Report # 224 (1882) by Rui Barbosa highlights a proposal for the creation of a Regular Gymnastics School, that does not seem to have been carried out in full. However, our military roots are clearly seen in the training of 20 civilian teachers, 60 monitors, 8 first lieutenants and two medic lieutenants in the Provisional Course of Physical Education (class of 1929) of the Military Centre of Physical Education (1922), which became the Army School of Physical Education1.

From 1930 onwards, several training fronts emerged, whether through the creation of higher education schools for training physical education instructors for schools or through emergency courses and training for gymnastics instructors, medics specializing in Physical Education, massage techniques and sports coaching2. In a more current context, the report on the history of undergraduate health courses revealed a 301% rise in the number of Physical Education courses (117 versus 469) between 1991 and 20044, and in a recent comparison, this exponential increase (1991=117, 2006=617, 2008=783) follows the trend in other health courses, but in greater proportion (PE=569%; overall=458%)4,5.

It is important to clarify that as well as Physical Education being considered a profession belonging to the health sector, it is also considered a profession and curricular element of the education sector. This fact is represented by the distinct training programs for the qualification of bachelors6 to work outside the school environment and of school teachers7. However, it is clear that health-related content can and should be addressed by trained teachers in the school environment, as noted by Loch8 and Nahas9. Yet, the scope of the ABENEFs covers bachelor degree programs in Physical Education, according to the grounds described in Fonseca et al5.

Continuous training in physical education in Brazil through graduate studies has also increased quantitatively since the first Masters’ courses in the country (USP, 1977; UFSM, 1979, UFRJ, 1980) until today, currently with 25 graduate programs, 13 of which offer masters’ and doctorate qualifications and 12 only masters’. The start of this teaching qualification process also expanded with its entry into programs in related fields and, especially, masters’/doctorate studies abroad, directly influencing the choice of an academic-practical orientation, which began within the field of Physical Education. After three decades since the first graduate courses in physical education and 80 years of initial training efforts, it can be asserted that Brazilian physical education has Eurocentric and American roots.

In terms of scientific research, physical education has more than 400 research groups featured in the CNPq search directory. We have scientific journals catalogued in leading indexation databases and publish in national and international journals, covering the fields of social sciences, humanities and, in particular, health sciences. There are several scientific and professional associations within the area of Physical Education, including the Brazilian Society of Physical Activity and Health, which seeks to bring together researchers from different fields of knowledge.

Despite the prominent and intense growth of Brazilian Physical Education and the recognition it enjoys in the international arena, we must consider that our profession is new in relation to the more traditional health professions, and also that our growth has been intense and apparently involving conflicts in some historical periods, so it is not uncommon to find reports in the literature about the subjugation of Physical Education to the interests of the nation state, including military and medical-health interests. These are all marks of the history of our profession, and especially of the generation of academics and professionals who have made and make great contributions, despite the inevitable frustrations inherent to the progress and setbacks experienced.

We can highlight, however, that in recent years, particularly in the late twentieth century and first decade of this century, the possibilities for intervention in physical education have expanded in size and shape; our profession is now regulated10, we have been recognized as a health profession11, academics expressed our importance to the SUS3 and, above all, at the 13th National Health Conference the motion for social control was declared in relation to the importance of physical education to comprehensive care5, 12. Alongside these achievements, we have also benefitted from public investments in training reorientation policies and
Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

ABENEFS: HISTORY, GROUNDS AND PRELIMINARY PROPOSITIONS

foundation and purposes

The creation of ABENEFS emerged through debates in physical education graduate studies at UFSC, in scientific events, and disturbing observations, here and elsewhere by authors, as well as dialogues with peers of physical education and experiences in service-learning initiatives with colleagues from other health professions. These observations and readings start to become clear and take shape as physical education is considered by policies/programs for initial and continuous multiprofessional training in health care. Finally, our certainties about the potential of physical exercise, in different practices, for physical and mental health care, both at an individual and collective level, as well as our suspicions about the limited time devoted to learning about health matters during physical education training, were confirmed.

Meanwhile, two important initiatives to respond to new demands for physical education training for health were implemented, marked by Physical Activities Sciences at USP/East in 2005, and the Physical Education Course - Health Modality at UNIFESP, in 2006. We therefore began to observe an epistemological incompatibility, with graduate training in physical education involving socio-political knowledge and technical and scientific expertise in health, but also having to consider many other demands in sport and its different aspects (education, leisure, participation, competition). More importantly, we wondered where the space and time could be made to take responsibility for theoretical guidelines, pedagogical guidelines, sets of practices compatible with inductive programs (PET-Saúde, Pro-Saúde, etc.), SUS guidelines and principles and other demands in different areas of intervention in physical education and health, throughout the entire training process.

ABENEFS was created, essentially, to attempt to respond to and provide solutions for these and other issues addressed in the previous essay. We are aware of our limits, but we also know that this struggle is minor in relation to the other challenges tackled by our masters of Physical Education and by many other scholars who have helped and help build our Unified Health System.

The purposes of ABENEFS, therefore, may be declared as follows:

i. To propose and support policies and actions to ensure coordinated actions between initial and continuous training in physical education with emphasis on health, in line with the organization of the Unified Health System (SUS) and other demands of individual and collective health;

ii. To propose and support policies and actions aimed at initial and continuous training and the training of teachers and professionals in Physical Education, who work in service training (intern supervisors and preceptors), in the SUS and other spaces of health intervention;

iii. Advise, when requested, on the creation, review and adaptation of political-pedagogical projects of undergraduate and graduate programs that address the teaching of physical education and health, while respecting, as a premise, any regional demands and vocations of health care;

iv. To represent members and graduate courses in Physical Education with an emphasis on health at the FNEPAS, the Ministry of Health, Ministry of Education and other governmental, scientific or occupational agencies and associations, that in some way involve matters concerning the initial and continuous training of the physical education graduate.

v. To integrate physical education courses with emphasis on health and governmental initiatives to strengthen the development of the field of Physical Education.

vi. To enter into agreements, cooperative arrangements or contracts with public or private entities in order to achieve its objectives.
SCOPE AND PRACTICES

In light of this presentation to peers, we cannot shirk our obligation to present some definitions about the scope and objectives of the study, as well as the grounds to justify the inclusion of physical education activities in the health sector. Again, we would point out that these are merely indications by the groups and do not necessarily represent the opinion of other colleagues in the field of physical education.

For the purposes of definition, physical education is a field aimed at training, investigation and academic-professional intervention to promote individual and collective physical activity. It is also considered a profession and a curricular element/discipline.

The field of physical education is basically composed of three areas of intervention, namely: Health, Education and Sports. In light of the set of accumulated evidence and knowledge produced in each of these areas, it would seem coherent and feasible that training, intervention and research in physical education be aligned to the ministerial organization of the Brazilian state and the arrangement of the economic sectors. Figure 1 illustrates this proposal.

![Figure 1. Possible structural organization of physical education](image)

In this model, we find that the respective areas of training, intervention and investigation of physical education can also be composed of sub-areas compatible with the organizations of the ministries involved (sport, education or health).

Specifically in the case of the health sector, we made an adjustment in accordance with our scope of intervention, designated as Physical Activity. Others may have a different opinion, but considering that definitions can be double-edged, and this text is not the stage for epistemic
Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

discussions, suffice to say we have adopted the term Physical Activity because it is easily recognized nationally or internationally by both laymen and experts. That is, it facilitates communication between peers, researchers, and especially relationships between professionals and students, professionals and patients or professionals and subjectss.

Physical activity is considered a human behaviour and, as per defined by Nahas (2010) “Human physical activity has equally significant characteristics and determinant factors of a biological and sociocultural order in the choices and benefits derived from such behaviour.” In other words, Nahas’ concept emphasizes that both the choices and perceived benefits in relation to physical activity depend on biological and sociocultural issues, without, however, establishing any value scale, in line with contemporary thought that seek to understand human complexity.

Meanwhile, Casperson et al (1985) descriptive and operational definition is accepted worldwide: “physical activity is defined as any bodily movement produced by the skeletal muscles that results in energy expenditure.” The caloric output is derived primarily from four contexts or domains: transport/locomotion, household activities, occupational activities/work, leisure activities. Leisure comprises most of the interventions of Physical Education, through the use of the content inherent in our professional practice, namely: gymnastics, exercise, dance, wrestling/martial arts, sports.

It is noteworthy that, although society in general recognizes that physical education is the primary motivator of intervention in physical activity, and even though scientific communities recognize that physical activity is the scope of Physical Education, one must acknowledge the transdisciplinary and multi-professional potential of that scope, in order to better establish academic and intersectorial boundaries and relations in terms of research and in terms of physical activity intervention.

Regarding research, it should be highlighted that physical activity can be performed in the light of the mother discipline and derivative disciplines of the natural sciences, social sciences, humanities and applied sciences, as well as areas of knowledge without any disciplinary “stability”. Therefore, knowledge of sub-areas of public health (epidemiology, social sciences and humanities in health, health planning and management) and clinical health (physiology, kinesiology, functional assessment, etc.), leisure, sport, education, urban planning, the environment and economics, among others, can help to a lesser or greater extent in the promotion of physical activity and the search for explanations of causes and consequences of the practice (or lack) of physical activity.

The same logic can be applied to intervention in physical activity behaviour, which is also not exclusive to any one profession, as although we consider physical education as being primarily responsible for promoting physical activity for different segments of society and life cycles, physiotherapy and occupational therapy also intervene in human physical activity in the rehabilitation and recovery of voluntary movement for work, leisure, mobility (ADL and IADLs) and other daily chores. Moreover, nutrition, psychology, medicine, nursing, as well as other health professions, also can and should understand the benefits and general recommendations for promoting physical activity.

We stress that these observations may not match the consensus among other professions, but no matter, this is a space precisely for sharing knowledge and practices, recognizing the tenuous lines of intervention, but aimed at comprehensive health for the reason of our existence: people!

Moving on, we recall that the benefits derived from physical activity through content of physical education and other professions are useful both for sedentary people and athletes, from sports training to competitive sports and from pregnant women (conception/baby)design/Baby) to the elderly. Finally, physical activity can be promoted individually, among groups, organizations, communities or whole societies. There is a body of forceful and moderate scientific evidence regarding disease prevention, treatment and health promotion through the practice of physical activity for people in different life cycles and conditions.

By virtue of this evidence, of the profile of morbidity and mortality caused by non-communicable diseases and injuries, and of the recognition of physical education for the Unified Health Health, among other academic and professional endeavours, physical activity has been included in the Pact for Health, specifically within the strategic actions of the National Health Promotion Policy (Pact for...
Life). Such fact has enabled the physical education profession to be included in actions related to the National Plan for Physical Activity, National Network of Physical Activity, Family Health Support Centres (NASF) and also in the newly created Health Academies Program. The different lines of care listed by the Department of Strategic Programmatic Actions of the Ministry of Health also include potential intervention in physical activity that we expect to be implemented in the near future.

In addition to these possibilities, Physical Education has historically participated in other interventions in public, private and voluntary sector spaces (NGOs, foundations, institutes etc.), through individual, clinical and collective interventions.

ORIENTATION FOR INITIAL TRAINING:
PRELIMINARY NOTES

Considering the range of possible spaces for intervention for physical education, a curriculum in physical education, in the health modality, must have clear objectives that are consistent with the possibility of intervention. In other words, training should be geared primarily to the entire life cycle for all levels of intervention and to all levels of health care. One therefore perceives the exciting and necessary challenge of our actions to help achieve comprehensive health care. Thus, physical education graduate courses, with emphasis on health, may have the following objectives:

**General Objective:** to train graduate professionals in Physical Education at a level of excellence, to intervene academically and professionally toward the promotion of physical activity, related to comprehensive health, throughout the entire life cycle, also with intervention levels and levels of health care in order to increase the chances of adoption and maintenance of a physically active and healthy lifestyle among individuals and groups, recognizing the different conditioning and determining factors underlying the complexity of human health.

The **specific goals** are:

a) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and health problems in pregnant women, children, teenagers, young adults, middle-aged adults and elderly people in various conditions.

b) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and injuries at the level of societies, communities, organizations, groups and individuals, and

c) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and injuries at the three levels of health care.

Of course, in light of other health categories, and even within the field of Physical Education, the specific objective of intervention at the second and third levels of health care may sound pretentious and hard to achieve. However, we are aware of our legal and technical limits of performance, a fact to be considered when moving into an intervention scenario in which we assume the roles of “protagonists” or “supporting parts”, depending on the level of care required.

The key issue in these preliminary propositions is that the academic community and young people interested in choosing a bachelor’s degree in Physical Education, with emphasis on health, understand that this type of training is directed primarily toward a profile of action that allows the graduate to move safely between the three strands (manager, trainer and entrepreneur) of the three economic sectors (public, private and social/voluntary sector) and in the life cycle, which can benefit from physical activity. In short, it is attempts to provide coherent and objective training for an activity profile that is clear, legitimate and decisive in dynamic contexts of the health sector.

Based on these assumptions, we developed a preliminary model to clarify our limits and possibilities in relation to the levels of care. To this end, we combined the simplified pyramid model of health service hierarchy with an adapted model of levels of intervention in physical activity. This idea is represented in Table 1.
Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

TABLE 1: Levels of Intervention of the Physical Education and Health Professional

<table>
<thead>
<tr>
<th>Service Locations</th>
<th>Levels of Care</th>
<th>Service Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations</td>
<td></td>
<td>Hospitals and Rehabilitation Centre</td>
</tr>
<tr>
<td>Groups</td>
<td></td>
<td>Specialist Clinics</td>
</tr>
<tr>
<td>Communities and Societies</td>
<td></td>
<td>Homes and Health Units</td>
</tr>
</tbody>
</table>

APC = Primary Health Care; ASS = Secondary Care Health; ATS = Tertiary Health Care; APAFS = Primary Care in Physical Activity and Health; ASAFS = Secondary Care in Physical Activity and Health; ATAFS = Tertiary Care in Physical Activity and Health

This model shows that training in Physical Education with an emphasis on health should enable horizontal and vertical movement, along tenuous lines focused on physical activity, but without losing sight of matters of comprehensive health care of individuals and groups. In Table 2, there is a brief description of the intervention segments split by levels of care in physical activity and health.

TABLE 2: Care Levels in Physical Activity and Health and their segments.

<table>
<thead>
<tr>
<th>Level of Care in Physical Activity and Health</th>
<th>APAFS = Primary Care in Physical Activity and Health</th>
<th>ASAFS = Secondary Care in Physical Activity and Health</th>
<th>ATAFS = Tertiary Care in Physical Activity and Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Intervention in Physical Activity</td>
<td>a) Societies and b) Communities</td>
<td>Groups and Individuals</td>
<td>Organizations</td>
</tr>
<tr>
<td>Segments</td>
<td>a) Countries/Nations, State, Regions, Cities.</td>
<td>Fitness Centres, Sports Clubs, voluntary sector, parks, squares, clinics, studios, personal training.</td>
<td>Companies, Hospitals, Clinics, *CAPS, Military Institutions, Churches, Hotels, Cruise Ships, Supplementary Health Services, Voluntary Sector (NGOs, Charities, etc.)</td>
</tr>
<tr>
<td></td>
<td>b) Small Cities, Districts, Neighbourhoods, Coverage Areas of Family Health Strategy and other service networks.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Although CAPS is in the secondary level of health care, in this model of physical activity it fits better into the tertiary level.

The small sample is extended with the inclusion of niches for each segment. For example, at the primary level (APAFS), interventions in societies include the sub-segment of cities, which, in turn, has niches such as government incentives offered through all three federation bodies to implement programs, such as the National Network of Physical Activity. Regarding the APAFS combination - Communities-Areas of coverage, there is the niche of the family health support centres (NASF) in their different modalities. In the case of the ASAFS combination, Groups-Fitness Centres, Academies, there are different niches of service organization, such as: care split by injury, by life cycle, by services/modalities or mixed. Finally, in an ATAFS combination, Organizations-Companies, there is the niche of industries which, incidentally, seems to be one of those that has more physical education professionals in health promotion programs, with enormous potential to approach the adult public and their families.

Finally, a compendium of the classification would be useful for illustrational purposes, but would not be suitable for this paper. It is, however, suitable to present some comments on the characteristics of each level of care in physical activity (Table 3).
### Table 3: General Characteristics of Intervention at Each Level of Care in Physical Activity.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>APAFS = Primary Care in Physical Activity and Health</th>
<th>ASAFS = Secondary Care in Physical Activity and Health</th>
<th>ATAFS = Tertiary Care in Physical Activity and Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity as an end purpose</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Socio-political knowledge</td>
<td>+++</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Technical/clinical expertise</td>
<td>++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>Approaches</td>
<td>Political and Environmental Informative</td>
<td>Social and Behavioural Informative</td>
<td>Social and Behavioural Political and Environmental Informative</td>
</tr>
<tr>
<td>Activity Profile</td>
<td>Management and coordination</td>
<td>Instruction</td>
<td>Management and instruction</td>
</tr>
<tr>
<td>Autonomy</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Multiprofessional relation</td>
<td>+++</td>
<td>++</td>
<td>++</td>
</tr>
</tbody>
</table>

This classification is intended to facilitate future career choices of students and, moreover, facilitate curricular organization. Obviously it is not without mistakes, grounds for criticism and improvement. Likewise, it is noteworthy that these are not watertight border lines, as there are also intersections between the levels of care.

Regarding APAFS, Physical Education professionals are assigned primarily to manage policies and programs for physical activity for large population groups, in partnership with other intersectorial actions, which fact calls for a latitudinal emphasis on multidisciplinary relationships. As a rule, physical education professionals will take charge of sports and leisure departments, coordinate physical activity promotion programs in municipal and state health departments or national, state or local projects that have primary aim of physical activity. As in primary health care (PHC), it is at the level of APAFS that the highest number of people can be reached and through which all physical activity promotion actions could be coordinated.

Regarding ASAFS, Physical Education professionals are assigned to carry out coordination or instruction activities. The physical activity programs/projects developed at this level are performed in organizations where physical activity is not the core activity; these are activities/services that represent a part of larger staff programs at companies, treatment at large hospitals, educational and sociocultural activities in rehabilitation centres etc. There is a certain degree of autonomy in relation to technical procedures, but a wide range of conceptual and declarative expertise is required to establish multiprofessional relationships with areas of health and administration, among others. As occurs at the level of tertiary health care, the ASAFS services should be adapted to the systems of organization and administration.

Regardless of the level of health care and the level of care in physical activity and health, it is known that the knowledge and practices of health professionals require practical technologies (hard, light-hard and light) and also knowledge foreign, not exclusively, to training and professional practice in physical education. The use of
Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

this knowledge requires, necessarily, that the training be based on a curricular structure or model that accommodates legal requirements in terms of specific aspects of the profession, the consolidation of knowledge in physical education, collective health and health-related physical activity. From this perspective, table four perhaps supports, in the broadest sense, the construction of curricula for the training addressed by the ABENEFS.

<table>
<thead>
<tr>
<th>Health Care</th>
<th>Level of Care in Physical Activity and Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care</td>
<td>APAFS = Primary Care in Physical Activity and Health</td>
</tr>
<tr>
<td></td>
<td>ASAFS = Secondary Care in Physical Activity and Health</td>
</tr>
<tr>
<td></td>
<td>ATAFS = Tertiary Care in Physical Activity and Health</td>
</tr>
<tr>
<td></td>
<td>Physical Education Content: Physical exercises, gymnastics, dance, wrestling/martial arts, games and sports.</td>
</tr>
<tr>
<td></td>
<td>Unit of knowledge of Broadened Training Human-society relationship; Biology of the human body; Production of Scientific Knowledge and Technology;</td>
</tr>
<tr>
<td></td>
<td>Unit of knowledge of Specific Training Cultures of human movement, instrumental technique, educative-pedagogical</td>
</tr>
<tr>
<td></td>
<td>Axes in Physical Education and Health Field and area identifiers; Policy and Management and Physical Activity and Health; Care in Physical Activity and Health; Knowledge Production and Divulgation</td>
</tr>
<tr>
<td></td>
<td>Natural sciences, social sciences and humanities</td>
</tr>
</tbody>
</table>

Health care encompasses everything involved in looking after human health, including actions and services of health promotion and the prevention, rehabilitation and treatment of diseases. Therefore, as a starting point, one can presume that all the health professions apply their training, intervention and research efforts with the goal of improving health care. Given this assumption, it seems reasonable that a curriculum for Physical Education and Health should also be organized in such direction, which is why the term Health Care is included in the first line of the curricular model/structure.

In the second line, the level of care in Physical Activity and Health is indicated, precisely to establish consistency with the goals of an initial training course in Physical Education and Health, as described above. In the third line, the contents of physical education emerge as essential means to achieve the objectives. The fourth and fifth lines contemplate legal requirements as per set forth in Resolution 07/2004. Then the axes in Physical Education and Health are possibilities to bring the traditional courses or modules of the field closer to other new knowledge and practices necessary for health intervention.

Finally, it can be seen in this model that studies regarding the life cycle in various health, socioeconomic and cultural conditions, must be included in all the methodological strategies adopted from the beginning to the end of the course. In other words, this is a crosscutting theme inherent to our practices, which, in turn, must be analysed and justified from the perspective of the natural sciences, social sciences and humanities. Among other obvious reasons for the need to contemplate popular wisdom, knowledge from other sciences form the basis of the model, a fact which further supports the presence of physical education among the health professions and within the academia.

In reviewing these suggestions, we must also consider the necessary establishment for revising our conceptions of curriculum, still structured around disciplinary units with learning apparently centred on the “banking view” of education. Perhaps this is not a situation exclusive to physical education, but the ABENEFS enjoys the support of other educational associations and the FNEPAS to learn more about active teaching-learning methodologies in professional health training.

In addition to what was described in this text, the ABENEFS is specifically involved in physical education training with an emphasis on health, because we know that there are teachers and students interested in abandoning the myopic pragmatism-centred training and adopting training based on an extended concept of health, focusing on pedagogical approaches that consider the actors involved as subjects of the teaching-learning-work process. In other words, abandoning training directed at the market reserve to adopt training aimed at
the professional profile equipped with a systemic outlook and habits of self-learning for collective action, in favour of population empowerment. This process involves bringing together the knowledge and practices of collective health with the scope (physical activity), content (physical exercise, gymnastics, games, sports, wrestling/martial arts and dance) of Physical Education and knowledge produced by physical activity related to health. It should be noted, however, that this process is slow and must be based on respect for the constraints of university structures, the history of each course and specific regional and cultural aspects. With respect for the boundaries and with focus on the process, for in health the product will never be finished.

FINAL CONSIDERATIONS

Even considering the limitations of the indications and ideas generated through the initial discussions of the authors, which so not necessarily represent the debate in the field of Physical Education, we hope to have achieved our goals in order to tighten our multidisciplinary relations health. We know that the challenges are multiple, but the effort and initial results seem to demonstrate a positive and significant correlation, as we have seen in the warm welcome afforded by the FNEPAS. We have the support of all education associations of health professions that now, more than ever, are also part of the history of physical education.

REFERENCES


18. Caspersen CJ, Powell KE, Christenson GM. Physical activity, exercise,
Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS


CORRESPONDING AUTHOR

Silvio Aparecido Fonseca
Av. Campeche, 1157, Bloco B2 – apt. 206 Cezarium Residence Club
Campeche - Florianópolis
88063-300 SC
silviofonsecatoledo@yahoo.com.br

Universidade Estadual de Londrina/Departamento de Educação Física; Universidade Estadual de Londrina/Programa de Pós-Graduação em Saúde Coletiva.