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RESEARCH

# SELF-CARE AND AUTONOMY: COMPETENCIES OF PRIMARY HEALTH CARE PROFESSIONALS ON HEALTH LITERACY

*Autocuidado e autonomia: competências de profissionais da atenção primária para promoção do letramento em saúde*

*Autocuidado y autonomía: competencias de profesionales de la atención primaria sobre alfabetización en salud*

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## ABSTRACT

The study investigates health literacy competencies among primary health care professionals in Umuarama, Paraná, Brazil. A cross-sectional survey was conducted with 88 professionals (84.6% of local physicians, pharmacists, and nurses). Results reveal a paradox: while 89.8% were unaware of the term and demonstrated moderate knowledge, self-assessment of skills and attitudes was high. Pharmacists underperformed compared to other categories. Professional experience correlated positively with competence levels. Participants identified limited time and lack of management support as predominant structural barriers. The findings point to an empirical practice that, although relevant, requires formal training and intentionality for HL to become an emancipatory educational strategy and improve care quality within the Unified Health System.

***Keywords:*** Health literacy. Primary health care. Professional competence.

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**RESUMO**

O estudo investiga as competências relacionadas ao letramento em saúde entre profissionais da atenção primária em saúde de Umuarama, Paraná, Brasil. Realizou-se um inquérito transversal com 88 profissionais, 84,6% do total de médicos, farmacêuticos e enfermeiros. Os resultados revelam um paradoxo: embora 89,8% desconhecessem o termo e demonstrassem conhecimento mediano, a autoavaliação de habilidades e atitudes foi elevada. Farmacêuticos apresentaram desempenho inferior às demais categorias. A experiência profissional correlacionou-se positivamente ao grau de competência. Os profissionais identificaram a escassez de tempo e a falta de apoio da gestão como barreiras estruturais predominantes à implementação do tema. Os achados apontam para uma prática empírica que, embora relevante, requer adequada formação e intencionalidade para que o letramento se consolide como estratégia educacional emancipatória dos usuários e qualificação do cuidado no Sistema Único de Saúde.

***Palavras-chave:*** Letramento em saúde. Atenção primária à saúde. Competência profissional.

**RESUMEN**

El estudio investiga las competencias relacionadas con la Alfabetización en Salud (AS) entre profesionales de atención primaria de Umuarama, Paraná, Brasil. Se realizó una encuesta transversal con 88 profesionales (84,6% del total de médicos, farmacéuticos y enfermeros). Los resultados revelan una paradoja: aunque el 89,8% desconocía el término y mostró un conocimiento mediano, la autoevaluación de habilidades y actitudes fue elevada. Los farmacéuticos presentaron un desempeño inferior. La experiencia profesional se correlacionó positivamente con el grado de competencia. Los profesionales identificaron la escasez de tiempo y la falta de apoyo de la gestión como barreras estructurales predominantes. Los hallazgos apuntan a una práctica empírica que, aunque relevante, requiere formación e intencionalidad para que la AS se consolide como estrategia educativa emancipadora y califique el cuidado en el Sistema Único de Salud.

***Palabras clave:*** Alfabetización en salud. Atención primaria de salud. Competencia profesional.

# INTRODUCTION

Health literacy (HL) is a relatively new concept with multiple meanings, but central to the practice of care. Defined by the World Health Organization (WHO) as "the set of cognitive and social competencies that determine individuals' motivation and ability to access, understand, and use information to promote and maintain good health"[1].

It is not limited to educational level or knowledge about health, as it also encompasses the ability to access, navigate, understand, and apply information within the context of the healthcare system[1–3]. More than that, it should be viewed as a mechanism for the individual—formerly a patient—to develop critical autonomy over their life and choices within the social context[4,5], not merely a new instrument of biopower[6].

Nutbeam points out that a subject's HL can be stratified into: functional, with basic skills for verbal and written communication about health; interactive, advancing to the ability to extract information and derive meanings; and critical, when the subject is capable of critical analysis and decision-making[7]. On the other hand, low levels of health literacy result in negative consequences, such as increased morbidity, hospitalizations, and healthcare costs, highlighting the importance of healthcare professionals as crucial facilitators in this process[8–10].

In Brazil, studies estimate that literacy levels are inadequate among a significant portion of the population, reaching higher values than 60% of the population, with variations depending on health status and the assessment tools used[11,12]. In the context of Primary Health Care (PHC), Marques and Lemos estimated that three-quarters of respondents have an inadequate level of health literacy, with a direct correlation to educational attainment[13], being noticed by professionals as the main factor responsible for non- adherence to medication[14].

The WHO's perspective[1] is particularly interesting, as it does not limit responsibility for healthy living to the individual, but holds the healthcare system as a whole jointly responsible for its promotion, since healthy

living is recognized as a human right that socially determines well-being and equity in access to healthcare[15]. From this perspective, it occupies a space within a soft-hard healthcare technology[16], as a body of knowledge that allows professionals to identify difficulties and adopt supportive measures not merely based on intuition or experience. With the appropriate intentionality, it gains the power for a dialogical practice central to mediating the subject's autonomy[5].

Despite this, evidence suggests a gap in knowledge, practices, and intentionality regarding the application of the HL concept by health professionals[17–19]. Understanding this scenario in the national context and discussing it is central to supporting the design of educational strategies, the incorporation of tools into care processes, and the reorganization of the system.

The study aims to explore the level of competencies and perceptions regarding HL among doctors, nurses, and pharmacists in Primary Health Care (PHC) in the municipality of Umuarama, Paraná, Brazil.

## METHOD

This is an observational, cross-sectional, and individual-level study, with data collected via a structured questionnaire to investigate the topic of HL among PHC professionals in the municipality of Umuarama, Paraná.

The municipality, located in the northwestern region of the state of Paraná, is the headquarters of the 12th Regional Health Department of the State of Paraná. In 2023, it had approximately 113,416 inhabitants, 24 Basic Health Units (BHU), 29 Family Health Strategy (FHS), and a population coverage of 83.5%[20].

The study population consisted of doctors, nurses, and pharmacists working in the municipality's PHC system, given their relevance in providing care for chronic conditions. Dental surgeons were excluded due to the specific nature of their professional practice.

With authorization from the Municipal Health Department, telephone contact was made with the coordination of each Basic Health Unit (BHU) to schedule the visit and invite the professionals. Up to three visits were conducted on different days and times at each unit, reaching 100% of the professionals on duty in October 2023. Professionals absent during this period due to vacation or sick leave were considered losses.

The questionnaire for evaluating the professionals was based on the concept of competence as the inseparable integration of knowledge, skills, and attitudes[21]. The questions were developed based on a review of the literature[18,22–24], with free translation and adaptation.

Comprising 34 questions, it was divided into sections: general participant information, specific knowledge, skills/attitudes, and barriers. The administration followed a structured script to ensure a standardized approach. The instrument was pre-tested with professionals from the target categories who did not work in the municipality of Umuarama- PR, and the information collected at this stage was not used for any purpose other than improving the instrument.

The first section of the questionnaire collected about each healthcare professional, such as profession, age, gender and graduation time, followed by a question asking whether the participant had had prior contact with the subject (Table 1).

In the second section, knowledge of HL was assessed through ten (10) true/false questions (Table 2), with the option to answer "I don't know." Each correct answer was worth five (5) points, and the total score for each participant was calculated at the end, with a maximum of 50 points. Answers such as "I don't know" did not count toward the score.

Before proceeding to the self-assessment section on skills and attitudes, the WHO definition of HL was presented to the professional. Ten (10) questions were then presented for the professional to evaluate their daily practice on a visual analog scale (Table 3), ranging from one (01 - I never do this) to five (05 - I always do this). The scale was added up, totaling a maximum of 50 points.

For descriptive purposes, the final section of the questionnaire aimed to identify the main barriers perceived by the professionals to better utilization of the concept of HL, where they could respond using a scale from one (01) – strongly disagree, to five (05) – strongly agree for each of the items presented. The values were categorized dichotomously, with responses of one to three (01 to 03) classified as "not barriers" and four and five (04 to 05) as "barriers."

For analysis, the independent variables were: gender, age, professional category, graduation time, and length of service in primary health care. The dependent variables (outcomes) were the level of knowledge regarding the study topic and self-assessment of skills and attitudes related to HL. The data were analyzed using IBM SPSS software (version 25) based on the response spreadsheet organized using the Google AppSheet application.

Characterization variables and responses to the questions were described using percentage distribution, medians, and standard deviation (SD). When collected in numerical/continuous format, the independent variables were categorized into two groups based on the median. The dependent variables, on the other hand, were categorized by the 75th percentile of the sample score.

The association analysis considered the Kruskal-Wallis test for differences in medians and, additionally, the Mann-Whitney test for variables with more than two categories. Given the nonparametric nature of the data and the sample size (n=88), it was decided not to use multivariate regression models to avoid compromising statistical power. An association was considered statistically significant at $p<0.05$.

This study complied with ethical guidelines and was approved by the Research Ethics Committee (REC) of the Universidade Estadual de Maringá (UEM), with CAAE No. NN [removed for peer review purposes].

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## RESULTS

In October 2023, 119 professionals from the categories under study were working in primary healthcare in Umuarama, Paraná. Of these, 104 (87.4%) were approached, and 88 interviews were conducted, corresponding to 84.6% of the total number of professionals: 47 (53.4%) doctors, 28 (31.8%) nurses, and 13 (14.8%) pharmacists. The category with the highest number of dropouts/refusals was doctors (20, 64.5%), followed by nurses (11, 35.5%).

Most of the participants were female, with an average age of 38. The majority (55.7%) had graduated less than 10 years ago, 64.3% held a postgraduate degree (specialization/master's/doctorate or residency), and 54.4% of the respondents had less than 5 years of experience in primary care (Table 1).

In general, the group of doctors is younger, with less time since graduation and a lower proportion of postgraduate degree holders. Along with pharmacists, they differ from nurses in having less experience in PHC (Table 1).

When asked if they had heard of "Health Literacy" before (Table 1), the majority of respondents (89.8%) said no.

**Table 1** - Characteristics of the Professionals Participating in the Study, 2023, Umuarama-PR.

| Demographic and professional characteristics | Professional Category, n (%) | | | Total n (%) |
|---|---|---|---|---|
| | Doctor | Nurse | Pharmacist | |
| | 47 (53.4) | 28 (31.8) | 13 (14.8) | 88 (100) |
| **Gender** | | | | |
| Male | 21 (44.7) | 4 (14.3) | 2 (15.4) | 27 (30.7) |
| Female | 26 (55.3) | 24 (85.7) | 11 (84.6) | 61 (69.3) |
| **Age, years** | | | | |
| Median (SD) | 35 (7.7) | 41 (6.8) | 41 (8.8) | 38 (8.0) |
| ≤ 38 | 29 (61.7) | 13 (46.4) | 4 (30.8) | 46 (52.3) |
| > 38 | 18 (38.3) | 15 (53.6) | 9 (69.2) | 42 (47.7) |
| **Level of education** | | | | |
| Graduation | 26 (55.3) | 1 (3.6) | 3 (23.1) | 30 (34.1) |
| Postgraduate | 21 (44.7) | 27 (96.4) | 10 (76.9) | 58 (65.9) |
| **Time to complete graduation degree, years** | | | | |
| Median (SD) | 5 (6.7) | 14 (6.3) | 18 (7.5) | 10 (8.0) |
| ≤10 | 39 (83.0) | 6 (21.4) | 4 (30.8) | 49 (55.7) |
| >10 | 8 (17.0) | 22 (78.6) | 9 (69.2) | 39 (44.3) |
| **Postgraduate program and area of concentration** | | | | |
| Did not complete | 26 (56.5) | 1 (3.8) | 4 (30.8) | 30 (35.7) |
| Public, community, or family | 8 (17.4) | 6 (23.0) | 0 (0.0) | 17 (16.7) |
| Other | 12 (26.1) | 19 (73.2) | 9 (75.0) | 41 (47.6) |
| **Time to complete postgraduate studies, years (among those who completed)** | | | | |
| Median (SD) | 2 (3.6) | 10 (5.7) | 10 (8.1) | 6 (6.2) |
| ≤ 6 | 16 (80.0) | 8 (30.8) | 5 (50.0) | 29 (51.8) |
| > 6 | 4 (20.0) | 18 (69.2) | 5 (50.0) | 27 (48.2) |
| **Years of experience in primary health care** | | | | |
| Median (SD) | 3 (5.2) | 8 (6.9) | 4 (7.8) | 5 (6.4) |
| ≤ 5 | 33 (70.2) | 9 (32.1) | 10 (76.9) | 52 (59.1) |
| > 5 | 14 (29.8) | 19 (67.9) | 3 (23.1) | 36 (40.9) |

When assessing the level of knowledge, the median score among participants was 30, out of a total of 50 points. In this section, the question with the highest correct response rate was regarding the use of techniques such as asking the user to repeat the guidelines, action plans, and demonstrations in their own words, with 93.2% identifying it as correct (Table 2). Conversely, only 20.5% (n=18) correctly identified as false the concept of providing a detailed, exhaustive, and repetitive explanation from the user's first visit (Table 2).

**Table 2** - Questions to assess the level of knowledge of the professionals participating in the study, 2023, Umuarama-PR.

| STATEMENT (CORRECT ANSWER) | Correct answers | |
|---|---|---|
| | n | % |
| Health Literacy refers only to a person's ability to read and understand medical terms (F) | 58 | 65.9 |
| Patients with high levels of education may have low health literacy (V) | 65 | 73.9 |
| People with limited health literacy tend to have lower healthcare costs (F) | 51 | 57.9 |
| One factor that increases the likelihood of low HL is age (F) | 37 | 42.0 |

| | | |
|---|---|---|
| HL is a specific component of the relationship between the medical professional and the patient (F) | 39 | 44.3 |
| To ensure good HL, it is necessary to explain the disease, existing treatment options, complications, and other relevant information in detail from the first consultation with the patient, repeating the information as many times as necessary (F) | 18 | 20.5 |
| Patient-centered care is a concept that considers the patient's active role in established therapeutic decisions (V) | 72 | 81.8 |
| Asking the patient to repeat in their own words what they should do, agreeing on action plans, and evaluating demonstrations of specific care are techniques for developing HL (V) | 82 | 93.2 |
| Regardless of the patient's characteristics, the primary objective of HL is to develop the user's skills, placing other actors such as caregivers and family members in the background (F) | 68 | 77.3 |
| It is only possible to identify the patient's level of HL through the application of validated assessment instruments (F) | 47 | 53.4 |

In the assessment of skill/attitude levels, participant's scores were close to the maximum of 50, with a median of 47 points. Among the questions that stood out, 96.5% responded that they seek to promote a friendly and comfortable environment so that the patient can express themselves freely (Table 3). The lowest score (72.7%) was for demonstrating empathy with the patient, even when the patient's choice contradicts the professional's recommendations, followed by sharing care with the family health team in complex cases (73.9%).

**Table 3** - Questions for assessing self-reported HL skills and attitudes among professionals participating in the study, 2023, Umuarama-PR.

| **Affirmative (Scale from 1 to 5)** | **Responded level 4 or 5** | |
|---|---|---|
| | n | % |
| I find it easy to identify typical characteristics of low literacy with: difficulties reading and interpreting prescriptions, nutrition labels, or even evaluating health information for decision-making | 79 | 89.8 |
| I try to identify, through the patient's behavior, when they are not understanding or will not follow the instructions I have given | 83 | 94.3 |
| Whenever necessary, I am able to adapt or diversify communication strategies according to the patient's needs, including in critical situations, such as with people who do not speak Portuguese | 68 | 77.3 |
| I strive to create a comfortable and friendly environment to encourage the patient to communicate freely about their concerns and difficulties in coping with their illness | 85 | 96.5 |
| I am able to show empathy and support patients in their decisions, even when they go against the best available recommendations | 64 | 72.7 |
| I feel capable of using strategies to promote patient self-care so that they can permanently change habits, such as smoking and consumption of ultra-processed foods | 67 | 76.2 |
| I strive to take responsibility both for the prescribed treatment and for providing guidance on where and how the patient can obtain it, facilitating their journey through the healthcare system | 78 | 88.6 |

| | | |
|---|---|---|
| Whenever necessary, in addition to the prescription, I strive to provide written information, use printed materials or drawings, and underline or highlight the information most relevant to the patient's understanding | 69 | 78.4 |
| I try to involve caregivers, family members, and other primary care health professionals in the consultations so that they can assist the patient in adopting the recommended behaviors | 79 | 89.8 |
| I seek to share the most complex cases with the ESF to establish individualized self-care goals and development plans for these patients | 65 | 73.9 |

When analyzing the correlation between HL components and other variables, it is not possible to infer that prior knowledge of the term HL influenced the professional's level of skills/attitudes (Table 4). While familiarity with the term HL was associated with higher scores in the knowledge dimension (p=0.02), when examining the relationship between dimensions, those who scored below 30 points in the knowledge dimension had higher scores in the skills/attitudes dimension (p=0.03).

**Table 4** - Analysis of median values for the level of knowledge and self- assessment of skills/ attitudes among study participants according to sociodemographic and professional characteristics, Umuarama-PR, 2023.

| Variable | Knowledge | | Skills and Attitudes | |
|---|---|---|---|---|
| | Median (points) | p-value | Median (points) | p-value |
| **Gender** | | | | |
| Male | 35 | 0.56 | 44 | 0.05 |
| Female | 30 | | 46 | |
| **Age, years** | | | | |
| ≤ 38 | 30 | 0.41 | 45 | 0.43 |
| > 38 | 35 | | 46 | |
| **Are you familiar with or have you heard of the term "Health Literacy"?** | | | | |
| Yes | 35 | 0.02 | 47 | 0.22 |
| No | 30 | | 44 | |
| **Occupation** | | | | |
| Medicine | 35 | | 45 | |
| Nursing | 30 | 0.03* | 45 | 0.01** |
| Pharmacy | 25 | | 36 | |
| **Time to complete graduate degree, years** | | | | |
| ≤10 | 35 | 0.84 | 46 | 0.69 |
| >10 | 30 | | 45 | |
| **Postgraduate program and area of concentration** | | | | |
| Did not complete | 30 | | 45 | |
| Public Health and related fields | 35 | 0.76 | 45 | 0.80 |
| Other | 30 | | 45 | |
| **Time to complete postgraduate studies, years*** ** | | | | |
| ≤ 6 | 33 | 0.51 | 47 | 0.28 |
| > 6 | 30 | | 44 | |
| **Years of experience in primary health care** | | | | |
| ≤ 5 | 25 | 0.01 | 46 | 0.88 |
| > 5 | 35 | | 45 | |

*Statistically significant difference: Pharmacy–Medicine (p=0.03).
**Statistically significant differences: Pharmacy–Nursing (p=0.02); Pharmacy– Medicine (p<0.01).
***Considering only professionals who have completed some form of graduate education.

When analyzing the factors showing differences with a low probability of being due to chance ($p<0.05$), it was observed that the pharmacist group had a lower number of correct answers in the HL knowledge section compared to doctors, as well as a lower self-assessment of skill/attitude levels, both compared to doctors and nurses. It is also noteworthy that longer tenure in PHC, exceeding five years, was associated with a higher number of correct answers in the knowledge dimension (Table 4).

The final part of the interview addressed the barriers identified by the professionals as impediments (Table 5), the main ones being: limited time for patient care (76.1%), lack of promotion by management (69.3%), and staff shortages (57.9%).

**Table 5** - Groups of barriers cited by health professionals regarding the use of the concept of Health Literacy within the primary health care system in Umuarama, Paraná, 2023.

| Barriers | Professional category (n, %) | | | |
|---|---|---|---|---|
| | Physician | Nurse | Pharmacist | Total |
| | 47 (53.4) | 28 (31.8) | 13 (14.8) | 88 (100.0) |
| Limited time for patient care | 40 (85.1) | 15 (53.6) | 12 (92.3) | 67 (76.1) |
| Lack of dissemination and implementation of the HL by management | 33 (70.2) | 18 (64.3) | 10 (76.9) | 61 (69.3) |
| Lack of Human Resources | 26 (55.3) | 14 (50) | 11 (84.6) | 51 (57.9) |
| Lack of knowledge about HL | 13 (27.6) | 6 (21.4) | 2 (15.4) | 21 (23.9) |
| Lack of Patient's HL | 14 (29.8) | 5 (17.9) | 1 (7.7) | 19 (21.6) |

## DISCUSSION

The characteristics of the sample reflect the current context of primary care composition, marked by an increase in temporary employment contracts among doctors[25] and the recent incorporation of pharmacists into PHC, though still limited to logistical functions (Table 1). The lower proportion of nurses relative to doctors within the Family Health Strategy (FHS) context is due to the difference in weekly work hours, with the former group working 40 hours per week and the latter, as a rule, 20 hours per week.

The lack of prior knowledge of the term HL (89.8%) should be understood from different perspectives. While, on the one hand, professionals may have developed these competencies through on-the-job learning[26], which is supported by the significant correlation between longer tenure in PHC (>5 years) and higher knowledge scores (Table 4), on the other hand, it draws attention to the possibility of a practice that may be limited to common sense, which makes it more difficult for the professional to support the development of the user's HL at a critical level, as defined by Nutbeam[7] .

The development of a healthcare model capable of addressing the epidemiological and demographic transition—marked by a higher burden of chronic conditions—requires a coordinated effort to reorganize the healthcare network and train professionals to adopt new technologies, such as HL[27]. In the context of undergraduate health programs, a systematic review conducted by Saunders et al. indicates that isolated or purely theoretical approaches are insufficient for the effective implementation of HL in professional practice. The topic must be integrated across the curriculum and supported by learning strategies in real-world settings so that it is truly incorporated by students[28].

Initiatives targeting in-service workers are as, if not more, relevant than adjustments to graduate programs alone, enhancing existing knowledge and enabling the observation of results in a shorter period of

time. Coleman and Fromer demonstrate that, in this context, short training programs in HL can be a powerful ally for managers to expand the problem-solving capacity of their health services[29]. However, it should not be restricted to a purely theoretical approach but must demonstrate the use of techniques and tools[30] so that they can be systematically applied.

The paradox between a lower level of knowledge and the perception of high performance in skills and attitudes suggests the presence of the *Dunning-Kruger* effect, in which a lack of knowledge about the subject prevents professionals from recognizing their own limitations[31]. Additionally, social desirability bias in PHC and the subjectivity of understanding may lead to high scores, such as, for example, in the promotion of a "friendly environment" (96.5%). Conducting studies that advance this understanding, using qualitative techniques and, above all, including the user in the evaluation process, is desirable for understanding the phenomenon.

When analyzing individual responses to the items, a finding that deserves special attention was that 79.5% of respondents consider the detailed and exhaustive repetition of information they deem relevant to be correct (Table 2). This is associated with the relative difficulty of exercising empathy when the subject's will contradicts the recommendations (Table 3). The fixation on the vertical transmission of knowledge, disregarding the reality and subjectivity of the other, represents the exercise of biopower[6] and places the professional in the role of a "cultural invader" by flooding, under a false pretext, the individual with information that is not processable in that situation[4].

It is imperative to overcome this merely instrumental bias to consolidate an emancipatory perspective on literacy, transforming it into a "practice of freedom," reinforcing that it is not enough merely to know the term or adopt behaviors aligned with it, but to understand its scope, tools, and intent[5]. In-service training programs that incorporate this approach, such as the one evaluated by Zanchetta and colleagues, prove effective not only in equipping workers but also in enabling them to recognize themselves as agents capable of influencing reality and promoting the autonomy of families and communities[32]. According to Mendes' proposal for reorganizing the health system, it is essential to be effective and efficient, it is essential that supported self-care be the primary focus in the treatment of chronic conditions[27]. This perspective is grounded in the Spectrum of Care Theory[33], which, in the British context, found that individuals with chronic diseases interact with professional teams for an average of three hours over the course of a year. In the remaining 8,757 hours, the individual manages their health autonomously. Thus, it would be illusory to believe that a prescriptive practice is capable of sustaining lasting changes in habits or healthy choices, which positions HL not only as an ethical choice but as a technical necessity.

Regarding the professional categories analyzed, pharmacists scored significantly lower compared to other professions, reflecting a profession historically neglected in terms of direct patient care in Brazil, remaining restricted to logistical and technical activities[34]. The fact that this is the profession that most frequently cited limited time with patients and a lack of human resources as barriers to implementing HL (Table 5) reinforces that this transition has not yet materialized. Looking ahead, research indicates that the introduction of clinical pharmaceutical services, which in some way support the development of users' self-management, results in a decrease in other consultations, emergency room visits, and reduced spending on primary and secondary health care[35].

Regarding the barriers faced by professionals in implementing HL (Table 5), the perception of limited time for care—shared by medical professionals (85.1%)—should not be interpreted solely as a chronological shortage. According to Merhy[16], healthcare materializes in the micro-politics of encounters, where there is a tension between dead work (equipment and protocols) and living work in action (listening and bonding). Overcoming the logic of numerical productivity is central to overcoming dead work, and without this, the HL will not be effective in addressing the singularities of individuals[9,36].

Despite this, an unexpected finding is that the practice of sharing more complex cases with the Family Health Strategy (FHS) was one of the lowest-scoring behaviors among participants (Table 4), revealing a contradiction. While professionals complain about a lack of individual time, they seem to underutilize the potential of the multidisciplinary team. The HL is not developed at the critical level necessary for self-care

in an isolated event or a single conversation; it requires a care plan, continuity, intentionality, and, above all, interprofessional collaboration[27] .

The lack of promotion and encouragement of HL use by management (69.3%), combined with a shortage of human resources (57.9%), highlights that, despite the existence of proposals and projects to change the care model[27], efforts have not been sufficient to ensure that literacy ceases to be an empirical and isolated activity and instead becomes an integral part of care processes.

This problem is not limited to the level of care or the municipality under analysis; it manifests globally, from the individual to the community level. According to Sørensen[15], a system's inability to provide accessible and navigable information constitutes a structural barrier to the full exercise of citizenship.

The concept of Health Literate Organizations emerges in this context, indicating that institutions must possess attributes such as leadership to integrate health literacy into the institution's mission, structure, and operations; workforce preparation and progress monitoring; facilitating user access to information; and user involvement in the design and implementation of actions, among others.

In Brazil, HL has made significant progress, evolving from being merely a subject of academic curiosity to becoming firmly established within networks of technical cooperation[38]. As it takes root in the national context, the concept will undoubtedly take on new forms, incorporating elements from fields such as popular education and social participation.

## CONCLUSIONS

The research conducted in the primary healthcare system of Umuarama, Paraná, indicates that the concept and practices of HL are intuitive in nature, with little theoretical organization. Most professionals, even without formal knowledge of the concept, engage in communicative practices that align with the general HL concept, shaped by daily life. This informal learning, however, may be insufficient to bring about the expected change.

More than just training and equipping professionals, it is crucial that the health system take responsibility for introducing these practices in pursuit of a care model better suited to chronic conditions.

Ultimately, HL must be constructed as a mechanism for the democratization of knowledge. If individuals with chronic conditions manage their own lives most of the time, the primary function of the healthcare system is to support this self-management, ensuring that the healthcare system functions not merely as a prescriptive space, although empathetic, but as a space for emancipation and the full exercise of civic autonomy.

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