HEALTH EDUCATION IN FAMILY HEALTH STRATEGY: PERCEPTION FROM THE PROFESSIONAL WORKERS

Health education in the Family Health Strategy: professionals' perception

Educación en salud en la Estrategia de Salud de la Familia: la percepción de los profesionales

Original Article

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ABSTRACT

Objective: To analyse the perception of professionals who work in the medical field at a Family Health Unit about the activities of health education during their job routine. **Methods:** Qualitative research from May 2012 to June 2012, through semi-structured interview with eight health professionals from different categories, at a Family Health Unit in the city of Recife, Pernambuco. The interviews were analyzed according each kind of content. **Results:** Among the interviewers, it is possible to notice the existence of a health education perception guided by the precepts of participatory education of critical and reflective feature, especially when the professional recognizes the community's knowledge and provides spaces for knowledge exchange and collective construction. However, this was not a unanimous concept since a conception of health education with the purpose of "teaching" what is "correct" was still identified, aiming for the adoption of healthier behaviorism. **Conclusion:** The professionals interviewed showed different perceptions about the health education activities. These perceptions included elements of both a more traditional practice, based on the transmission of information, as well as ideals of an emancipatory practice that values popular knowledge and invites individuals to be co-responsible for health care.

Keywords: Health Education; Health Promotion; Perception.

RESUMO

Objetivo: *Analisar a percepção dos profissionais de saúde de uma Equipe de Saúde da Família sobre as atividades de educação em saúde conduzidas na rotina de trabalho.* **Métodos:** *Pesquisa qualitativa realizada no período de maio a junho de 2012, mediante entrevista semiestruturada com oito profissionais de saúde de diferentes categorias em uma Unidade de Saúde da Família (USF) localizada em Recife-PE. Analisaram-se as entrevistas mediante análise de conteúdo por meio da modalidade temática.* **Resultados:** *Entre os profissionais entrevistados, pode-se identificar que existe uma ideia de educação em saúde pautada nos preceitos da educação participativa e de caráter crítico-reflexivo, principalmente quando o profissional reconhece o saber da comunidade e proporciona espaços de troca de conhecimento e construção coletiva. Entretanto, isso não foi um conceito unânime, pois ainda identificou-se uma concepção de que a educação em saúde tem o propósito de "ensinar" o que é "correto", objetivando a adoção de comportamentos mais saudáveis.* **Conclusão:** *Os profissionais entrevistados apresentaram percepções distintas sobre as atividades de educação em saúde. Essas percepções contemplaram elementos tanto de uma prática mais tradicional, pautada na transmissão de informações, como ideais de uma prática emancipatória, que valoriza o saber popular e convida os indivíduos a serem corresponsáveis pelo cuidado em saúde.*

Descritores: *Educação em Saúde; Promoção da Saúde; Percepção.*

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RESUMEN

Objetivo: *Analizar la percepción de los profesionales de la salud de un equipo de Salud de la Familia sobre las actividades de educación en salud conducidas en la rutina del trabajo.* **Métodos:** *Investigación cualitativa realizada entre mayo y junio de 2012 a través de entrevista semiestructurada con ocho profesionales de salud de distintas categorías en una Unidad de Salud de la Familia (USF) localizada en Recife-PE. Las entrevistas fueron analizadas mediante el análisis de contenido a través de temáticas.* **Resultados:** *De los profesionales entrevistados se identifica una idea de educación en salud basada en preceptos de la educación participativa y del carácter critico-reflexivo en especial cuando el profesional reconoce el saber de la comunidad y promueve espacios de cambio de conocimiento y la construcción colectiva. Sin embargo, eso no ha sido un concepto unánime pues se identificó, además, una concepción de que la educación en salud tiene el objetivo de "enseñar" lo que es "correcto", para la adquisición de conductas más saludables.* **Conclusión:** *Los profesionales entrevistados presentaron percepciones distintas de las actividades de educación en salud. Tales percepciones incluyeron elementos de una práctica más tradicional basada en la trasmisión de informaciones como ideales de una práctica emancipatoria que valora el saber popular e invita a los individuos a tener la responsabilidad por su cuidado en salud.*

Descriptores: *Educación en Salud; Promoción de la Salud; Percepción.*

INTRODUCTION

The activities of education in health have been used in the Family Health Strategy (*Estratégia Saúde da Família - ESF*) as an empowering key for health promotion actions and approach between the professional practice and the reality of each population[1-3]. However, the way these activities have been made can often take a conservative and vertical approach, making it a prescriptive practice that denies reflection and participation of the population in the construction of their health[4].

This kind of more conservative approach has its history linked to the principles of health education, guided by encouraging the adoption of healthy habits and transmission of knowledge, disregarding the relationship between diseases, conditions and social determinants of health[5,6]. This kind of traditional, normative and imperative approach still prevails in health services that encourage individuals or families to adopt habits and behaviors considered appropriate for the effective implementation of health[3,6].

However, professionals have attempted to insert education into the public health system that promotes the autonomy of individuals, through a dialogic and reflective practice[7]. Essa prática é entendida como um elemento produtor de um saber coletivo que possibilita ao indivíduo sua libertação para cuidar de si, da família e do seu entorno social This practice is understood as an element that produces a collective knowledgement which enables the individual freedom to take care of themselves, their family and their social environment[8].

According to this perspective, the ESF appears as singular place for the incorporation of different health education practices[9], in which professionals can develop their work beyond the physical site of health facilities, using the already existing social facilities. Therefore, it is possible that these professionals have a closer contact and recognition of local realities, often leading them to realize and understand the individuals from their sociocultural context[10].

However, some studies[3,9,11-13] shows that the ESF professionals take an educational approach based on the matter of searching for "awareness" through transfer of knowledge, in order to encourage lifestyle changes through corrective and imposing stance. In addition, these professionals still face many barriers to the implementation of health education activities in the routine of services, among them the lack of material, inadequate space and little support from management[14].

Before the given situation above, the question is: what is the conception about health education in the activities conducted by health professionals in the work routine?

Therefore, in order to contribute to the discussion on this theme, this study aims to analyze the health professionals perception of a Family Health Team on health education activities duringin the work routine.

METHODS

It is a qualitative study, an exploratory-descriptive kind, held from May 2012 to June 2012 with health professionals from a Family Health Unit (USF), located at the Health District II of Recife-PE. The choice of the unit is given for convenience because it was space intervention of Multidisciplinary Residency Program in Health at the University of Pernambuco. In the administrative area of health, the city of Recife is divided into six health districts, and this one consists of seventeen USF (Municipal Health Plan 2010/2013)[15].

They selected the participants of this study by drawing among the professionals, ensuring the participation of each professional category that makes up a Family Health Team (doctor, nurse, dentist, technical nursing, oral health assistant and community health agent). In addition, it was considered the sampling technique saturation of information to establish the final sample[16,17].

It was used as a technique semi-structured interview to obtain the information, made by one of the researchers. The interview was organized in two thematic blocks: "Health education" and "professional participation in health education activities." The blocks have addressed the following guiding questions: What is your perception about health education? What are the health education actions in the routine of USF? Which factors encourage or limit the realization of health education activities? What professionals are responsible for carrying out health education activities?

For data analysis, transcribed up the interviews completely and, after repeated readings, the units of meaning were captured and coded, using the method of content analysis through thematic modality, which allowed emerge from the questions guiding categories analysis for each thematic block[18]. They were: "Perception of health education; Identification of health education actions in the routine of USF "; "Factors that stimulate or limit the realization of health education activities"; and "Professional responsible for carrying out health education activities." They were analyzed descriptively and in accordance with the literature which discusses the topic.

The study was approved by the Research Ethics Committee of the University of Pernambuco (CAAE: 01691012.2.0000.5207), which is in accordance with the Resolution of the National Health Council, No 466/12. The interviewed professionals signed an Informed and Free Consent Term, being previously informed about the objectives and methods of the study. In order to maintain the confidentiality of the identification of professionals, they are presented by codenames (P1, P2, P3...).

RESULTS AND DISCUSSION

The information obtained in this study present, on the following, na understanding that health professionals have about health education through thematic categories.

Perception of health education

The category highlights the professionals understanding on health education. Part of a speech leads to an exchange of knowledge between them and the individual. This concept of health education based on respect for learning from each other and appreciation for the collective construction refers to the concept of Popular Education in Health:

> *"[...]Health education is an exchange of knowledge itself, it is the knowledge of our community, it is their culture, and we increase with ours, with our knowledge." (P2)*

> *"[...]I think we have to appreciate what people know, right? [...]Popular education, 'popular' implies: education to the people, to make people aware that they are protagonists of their own health." (P8)*

When it is observed that, in the context of health education practices, a progressive appreciation of representations and knowledge of the individuals and their community, more accurate becomes critical to the supremacy of scientific knowledgement in relation to popular knowledge[19].

Health education requires that the facilitator is open to the social, geographical, political and cultural development of individual, family and community[8]. In this study, it was noticed that these exchanges of knowledge can be built from conversations, moments mentioned by the professional as dialogue places in which an "array" of alternatives is shown in order to allow the individual to have the right to choose. Thus, the option of treatment or another topic discussed is not something imposed, but placed as an alternative:

> *"It is a job that we have to leave ... we have to explain to the people through conversations, dialogues. It [Is] not one-sided conversation, but dialogues that you establish with people in the community, either individually or in groups [...]It has to be clear [the] damage, benefits that people have for their life and family health." (P6)*

This practice leads to an education about non-normative health, stimulating behavioral changes, without imposing them[4]. It must be discussed with individuals to reflect their own reality and may choose for healthier choices.

Another idea linked to health education is that this one serves as an induction tool for changing in risk behaviorism by individuals and the community. Such perception supports the most traditional model of health education, which believes that health education based on the transfer of information may result in the adoption of so-called healthy behaviorism:

> *"If you are educating that community, educating about how to take care of itself, how it does to improve its life, gets out of inactivity, does a physical activity, improves nutrition [...]." (P5)*

> *"[...] It is you working as part of educating the community in a better way of living [...]." (P7)*

This practice that disregards the context of each person or community life was used in the early twentieth century to establish educational activities seeking to develop the adoption of healthier behaviorism by the individuals[20]. However, choices made by individuals are not independent from their living conditions, culture and their story. The process of education is actually a matter of searching the individual awareness, having its strategic direction its own

life story; otherwise, what you want to teach will not have any effectiveness because it will be a lot far away from its reality[21].

The search for "awareness" of the individual happens as it reaches a critical and reflective look of your reality, which in fact is not just the act of transmission of health-related information, although this point can raise awareness and stimulate them to understand their reality from a new perspective[13].

Identification of health education interventions in the USF routine

According to the professional speech, health education actions developed during USF routine are mainly focused on the groups training activities:

> *"When we work with groups, we are doing action of education ... education in health." (P2)*
>
> *"I work a lot with the group because the group ... in my opinion ... it spreads the best [...]." (P4)*

The actions developed in group spaces are good for the search for collective solutions, in which individuals are a support for the facing of the individual issues and / or problems experienced by the community[9]. However, despite the strategic direction of health education activities for the formation of groups, it was identified in the reports of the following professionals the possibility of carrying out health education activities in other public community spaces:

> *"[...]Education groups, lectures, meetings with the community, even us participating in the community struggle to get the new health unit, this is all in health education." (P1)*
>
> *"[...]These activities are either collective or individual ones, as the group I have once a week and I have the appointment daily. So, so, my focus is more on a daily basis in the clinic and my actions are more ambulatory [...]." (P6)*

So the ideas of these professionals support the presented one[19], in which health education activities can be undertaken in different contexts, such as in homes, during the visits, in schools, outpatient care, in the workplace or in any other public place.

Factors that stimulate or limit the realization of health education activities

Among the factors that stimulate the professionals to do the health education activities, the category highlights the possibility to promote a greater community involvement and approach to the activities of the health unit:

> *"When I see it... I go to a visit or here at the health unit through that work we did [...],the community, the way it is behaving well differentiated, it is ... different. It is interested, she comes ... asks,this is it." (P1)*
>
> *"Yeah ... first, to create connections with people in the community [...];second is the accession, general membership to attend, to know you can count on the health unit, treatment accession, he can understand more, it is more important [...].So, are the actions that allow a better relationship, better accession and a better understanding of health." (P6)*

Motivational factors indicated by the professionals interviewed converge to the results presented[22], when the authors identify that the health education activity is an important aspect for the creation and strengthening of the bond between the professional and the user, in addition to promote critical awareness sites and assimilation of the individual as a social actor.

Regarding the knowledge that the community owns, and the "lack" of it, it was also identified as a factor that stimulates the realization of health education activities in the routine of USF professionals:

> *"What excites me is to know that people know [...],It is to make them not only know, but they pass the wisdom to others [...]." (P4)*
>
> *"[...]You see the poverty of the people, the low knowledge level. So, a lot of what you see and that you could have avoided if it had a greater guidance [...]." (P7)*

According to the authors[6,23], the principle of educating, in many cases, comes from the hypothesis that most of the health problems is a result of lack of knowledge by the population - which therefore needs to be "educated" - relying on the idea that the seizure of scientific knowledgement would promote the acquisition of new behaviorisms. However, the simple act of communicating on health does not mean the individual, now a knowledge owner, will adopt a "proper" lifestyle.

Among the factors that restrict health education activities, the category shows that develop educational activities in FHS routine seems to be, according to the speeches of professionals, a chore. Several factors make it difficult and sometimes limit these activities, many of them arising from the municipal management process and the professional work process implementation and prioritization of demands:

> *"[...]The requirement, so ... of serving, a rate for service, you have to achieve that percentage of queries." (P1)*

"[...]Sometimes the materials are difficult to be understood by the people, sometimes are posters with too much information, which complicates rather than facilitates [...]." (P6)

"[...]It is the physical site that we do not have. A lot of times, we have the will, but there is not enough physical site that would fit to make up a group." (P7)

"The system itself ... the system management. Because, well, managers have to have a lot of goodwill, but the culture itself is a barrier. So ... for example: I have no paper to work at SUS, materials ... simple things." (P8)

Similar data were observed in a study that took place[12] in a city of Alagoas that presented the perception of the FHT professionals about the factors that limit the performance of health education activities. Among these factors some can be highlighted such as the lack of a proper place, the lack of illustrative materials easily understood by the population, the working hours of professionals and the need of a different view from the municipal management. Despite other studies[14,24] also present convergent results about the factors considered as barriers to educational practice in the FHS, it is believed that the ESF provides a unique opportunity for this practice and, to carry out health education activities, they do not require very high technologies. This educational process takes place with people, becoming more important than the physical and material resources[25].

Another point that calls attention as a limiting factor, even though it was presented for only one of the interviewed professionals, is how the health education activities are designed and implemented by health professionals. To recommend actions that are not related to real life situations and interest of the population makes it be apart or a passive spectator only:

"I think one of the limits is also the person (healthcare professional) who does not even understand what is popular education, which is not difficult because, well, popular education is you really see what the other wants to hear, it is not to make him listen what you mean. What does he really want to listen to? This is education. This block is there, then to come and say: 'you have to hear this, it will be good for this guy', but is this exactly what he wants?" (P4)

To understand the way of thinking and acting of people and the community helps to better understand their actions and /or behavior before certain problems[26]. Also, when health professionals expand their knowledgement trying to get the population comprehension, searching for educational approaches, with an emphasis on popular participation, it creates spaces in which these individuals have guaranteed their representativeness.

The idea presented by the professional supports the developed study [6] when discussing health education not as a tool whose purpose is to make people be concious, to educate, awaken, raise awareness (as the official health education programs intend) or just identify needs, but as an education that should consider important what people do best: their story, their time and their creation capacity.

Professional responsible for carrying out health education activities

Despite all the professionals consider themselves as responsible for carrying out educational activities, the category shows that the Community Health Agent (CHA), Agente Comunitário de Saúde ACS (in portuguese), was appointed as the main conductor, taking into consideration the its representation within the community, and it is considered a link between this and the others professionals/ health facility. From this perspective, this would mean the professional representation of the community, for having its life developed in this place, so it knows the local customs:

"Everyone, particularly the health care provider. They have more access to the community." (P1)

"Right away, the community health worker [...].It is the most important representative of the community [...]. I think it has to be the community health worker because he is the one who knows Dona Bio, and also knows how Dona Bio speaks. He knows the words are necessary to make Manoel understand, right? And other professionals should support him." (P4)

A major problem faced by the Family Health Teams is the "no understanding" of language and world view concepction of these communities[4]. Therefore, it has a fundamental importance the ACS role as moderator of the dialogue between the healthcare team and the community. As part of it, this professional knows the problems, needs and local culture (4).

The study developed[26] supports this understanding presenting a reflection on the role of ACS as a mediator of educational activities based on the Popular Education in Health theory. This health worker carries a potential in the process of mediation between different knowledge and logic, being able to promote resilience to the dichotomy of relations between health professionals and population.

Despite the importance of the ACS work with the educational activities, the other respondents believe that all workers should be responsible for health education activities:

"There is not only one person, you will be responsible for the group. No, here everyone has a very good contribution to give." (P2)

"All professionals [...],from the general service, vigilant, nursing technician, dental assistant, dentist, doctor, nurse ... all, I think, are responsible to work with health education.." (P5)

Under the ESF, education in health has become a planned activity and a duty to all who makes part of the team[27].

FINAL CONSIDERATIONS

According to the education perception analysis of health professionals interviewed, one can identify that there is an idea of health education based on the precepts of participatory education and critical and reflective character, especially when professionals recognize the knowledgement of the community and provides places to share experiences and collective construction. However, this is not a unanimous view among professionals because there is still an idea that health education has the purpose of "teaching" what is "correct", aiming the adoption of healthy behaviors. Despite this divergence of perceptions, the scenario seems encouraging because the traditional view has not prevailed among the interviewed professionals.

In addition, it was observed, from the participatory educational practice, an extension in the possibility of carrying out health education, which in this study was not restricted to the health facility, extrapolating to community social facilities and being seen as an instrument of mobilization and integration between the ESF and the community, strengthening connections and boosting co-responsibility in health care.

On the other hand, the differences of comprehension of the professionals who answered the questions of the interviews on the language of the people in the community, health education models (traditional conception versus participatory design) applied by plenty of professionals and the shortage of space and material resources reported did not represent major barriers to development. On the contrary, it is noticed among them an enthusiasm for the activity itself at various moments during the interviews. But the work of management in primary care focuses on health education activity in ACS, making it difficult to incorporate them into the agenda of other professionals, a task accumulation to be done in the healthcare field, making the ESF lose space for health education, essential tool to promote health and transform health practices.

Regarding to the major difficulties in conducting this study, we can highlight the need for more time for the interviews, since they have occurred individually. To the health team, to allow a professional to participate in in-depth interviews creates a burden to the other professionals, impacting on the organizational health unit process.

It is suggested that this study be submitted to healthcare managers to discuss strategies to overcome the difficulties, including a process of training teams, the incorporation of health education on the agenda of all professionals and other future studies in order to go further in investigating the health education practices conducted on daily lives of the Family Health Teams, using different methodological strategies.

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