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ORIGINAL ARTICLE

HEALTH EDUCATION AND USER´S EMPOWERMENT OF THE FAMILY HEALTH STRATEGY

EDUCAÇÃO EM SAÚDE E EMPODERAMENTO DO USUÁRIO DA ESTRATÉGIA SAÚDE DA FAMÍLIA

EDUCACIÓN EN SALUD Y EMPODERAMIENTO DEL USUARIO DE LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

Objective: to analyze the perception of workers of the Family Health Strategy on health education as a tool for patients´ empowerment of health services. ***Method***: it is a descriptive, exploratory study with a qualitative approach. Semi-structured interviews that were later subject to thematic analysis were used. Such a study was done in Family Health Units of the Health District I in the city of Uberaba, Minas Gerais. ***Results***: health education is still seen as an immediate response to identified problems, and be focused on providing training courses and lectures linked to a bank education and little problematical. ***Conclusion***: educational practices in the health services have not favored the community instrumentation for self-care and the development of the autonomy of the subjects, pointing to the need for further research on this theme. ***Descriptors***: Health Education; Empowerment; Family Health Strategy.

RESUMO

Objetivo*:** analisar a percepção de trabalhadores da Estratégia Saúde da Família sobre a educação em saúde como ferramenta para o empoderamento do usuário dos serviços de saúde. ***Método*:** estudo descritivo-exploratório com abordagem qualitativa. Foram utilizadas entrevistas semiestruturadas que, posteriormente, foram submetidas à análise temática. Tal estudo foi realizado em Unidades de Saúde da Família do Distrito Sanitário I da cidade de Uberaba, Minas Gerais. ***Resultados*:** a educação em saúde ainda é tida como uma resposta imediatista aos problemas identificados**,** além de estar centrada na oferta de cursos de capacitação e palestras vinculados a uma educação bancária e pouco problematizadora. ***Conclusão*:** as práticas educativas em vigor nos serviços de saúde não têm favorecido à instrumentalização da comunidade para o autocuidado e nem ao desenvolvimento da autonomia dos sujeitos, apontando para a necessidade de investigações mais aprofundadas acerca dessa temática. ***Descritores: Educação em Saúde; Empoderamento; Estratégia Saúde da Família.

RESUMEN

Objetivo*:** analizar la percepción de trabajadores de la Estrategia Salud de la Familia sobre la educación en salud como herramienta para el empoderamiento del usuario de los servicios de salud. ***Método*:** estudio descriptivo-exploratorio con enfoque cualitativo. Fueron utilizadas entrevistas semi-estructuradas que, posteriormente, fueron sometidas al análisis temático. Tal estudio fue realizado en Unidades de Salud de la Familia del Distrito Sanitario I de la ciudad de Uberaba, Minas Gerais. ***Resultados*:** la educación en salud todavía es vista como una respuesta inmediatista a los problemas identificados**,** además de estar centrada en la oferta de cursos de capacitación y palestras vinculados a una educación bancaria y poco problemática. ***Conclusión*:** las prácticas educativas en vigor en los servicios de salud no han favorecido la instrumentalización de la comunidad para el autocuidado y ni al desarrollo de la autonomía de los sujetos, puntuando la necesidad de investigaciones más profundas acerca de esa temática. ***Palabras clave: Educación en Salud; Empoderamiento; Estrategia Salud de la Familia.

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INTRODUCTION

The 1980s is marked by a reform process in global public health. In Brazil, this movement is evidenced by the Health Reform, which combined community participation in the composition of a new health care model, culminating in the 1988 Brazilian Constitution, with the proposal of a new health system. Together with this movement, the First International Conference on Health Promotion occurred in Canada that arose through the growing expectations for a new world public health.[1-2]

At this conference, the concept of Health Promotion was defined as a community training process in favor of actions for improving their quality of life and health.[2] Therefore, it is evident the democratization process in thinking about care in health, the result of collective construction, mirrored in the context of life of the actors of that time. From this perspective, health promotion provides empowerment as a possibility of individual emancipation and formation of the collective consciousness, contributing to people or groups to be prepared to change in their daily lives.[3-4] Also, it presents a new approach to character of educational practices by strengthening the capacity of individual choice.[5] This means that they must actively participate in the decision-making process and implementation of strategies for improving their health. Thus, it is seen the democratization of the planning of health care, guaranteed by the Constitution and the Organic Laws of Health, especially law 8142 of 1990.[6]

Therefore, the process of creation of local management councils begins in Brazil allied to health care facilities to carry out community participation in the planning of health actions and should serve as effective channels of communication between population and health professionals, as well as a device to exercise citinzenship.[7] Thus, there is a need for dialogue between health professionals through educational strategies for the public awareness, as is clear in the daily services, the health education still not effective as a tool for the empowerment of users, restricted to specific actions such as educational groups carried out vertically, with little or no participation of patients´ service in the planning and organization of actions.

In this sense, the Family Health Strategy (ESF) should act as a great ally and promoter of democracy through actions aimed at empowering users of health services, by being close to the local context, serving a specific population and characteristics defined, also to promoting the empowerment of managers and workers/health professionals as contributing to reflection and participation in political life.[8,9]

The ESF was created in 1994, initially as an adopted program to reorganize the Primary Health Care (APS) and redirect the care model through an educational practice focused on health promotion and disease prevention, for development of self-care and the improvement of access to social services.[8,10,11]

Concerning educational practices, there is the health education as enabler of knowledge to the promotion and protection of individual and collective health.[2,8,12,13]

Therefore, it is asked whether in the daily lives of the Family Health Units (USF), health education has been a tool used to empower the user towards democratization of actions aimed at social control in health, including social control as a power democratization strategy, space and as a channel of communication and expression of community participation in decisions to be taken at all levels of management.[14]

OBJECTIVE

- To analyze the perception of workers of the Family Health Strategy on health education as a tool for user empowerment of health services.

MÉTHOD

Descriptive and exploratory study with a qualitative approach. The study scenario was composed by the USFs of the Health District I (DS I) of the city of Uberaba, Minas Gerais.

The DS I has 20 family health teams, which was drawn randomly by a member of the staff, using a list of all the names of the workers of this ESF District, 01 health worker each.

Therefore, there were 20 health workers study participants who met the inclusion criteria: be ESF worker and accept to participate in the interview. Data collection occurred through semi-structured interviews during the period of August-September/2010, in the participants´ workplace with previously scheduled meeting. The interview had as guiding questions: Tell me what do you mean by health education; Tell me what do you mean by community empowerment; Do you believe there is a relationship between health education and community empowerment?; Is this accomplished here in the service? If so, how?

Respondents were identified as E1, E2, E3 and so on until E20 and before the interviews, participants read and signed the Informed Consent Form (TCLE). The ethical standards of Resolution 466/12 were followed and the research project was approved by the Ethics Committee in Research with Human Beings of the Federal University of Triângulo Mineiro (UFTM) by the opinion 1618.

The interview was recorded and transcribed in full and the data submitted subsequently to thematic analysis, to carry out a pre-analysis, which consisted of the transcript and read all the interviews and then execution of text clippings in units of records (keywords, phrases or passages). Since then, the operation of all the material was made, turning information into core reading comprehension and subsequently analyzed by categorization through the repetition of words and/or meanings that were grouped and interpreted.[15]

RESULTS

Based on 20 interviews carried out, it was possible to abstract 216 units records, which were divided into three themes: *1) health education, 2) Empowerment concept and 3) Linking Health Education and Community Empowerment*.

The Health Education theme was divided into three sub-themes: *Conceptions of Health Education; Actions developed in Health Education; Health Education Challenges*.

The sub-theme *Conceptions of Health Education* reveals the understanding of health workers on health education. For them, it consists of a user right, linked directly to disease prevention and that the way to execute it occurs mainly through instructions given by professionals. Some reports exemplify this sub-theme:

> *Health education is you always clear to the user, the customer´s Health System, which he has and how you can help him, then you will educate, re-educate him. (E15)*
>
> *Teaching as far as possible, the person taking care to avoid getting sick [...]. (E20)*
>
> *We reap the team information and passes it to users, the information [...] information that leads us to people. (E1)*

In the sub-theme *Actions Developed in Health Education*, respondents articulate health education with the practice of educational groups and lectures aimed at a target people, usually composing some of the health care programs in primary care. The following examples show these perceptions:

> *We do here a lot of health education in HIPERDIA group, diabetes group, pregnant group, childcare group. (E9)*
>
> *Here we do a lot of lectures, to transmit, to pass to the user how it should educate within health [...]. (E7)*

In the sub-theme Health Education Challenges, it was pointed out the difficulties identified by respondents to the achievement of health education in professional practice, being one of the hot spots limitations to ensure the attention and participation of users in educational activities carried out by health professionals. The following stories illustrate this perception:

> *[...] So, they do not want to hear us talking in their heads, not guidance, they want the medicine and that´s it. (E6)*
>
> *We try to make groups [...] but most of the population does not come. And when they come, they come to exchange for something. (E6)*

Also, respondents reported difficulties in establishing a partnership with the population in favor of implementation of health education activities due to a historical process settled on a model of health care welfare and inarticulate with prevention and health promotion.

> *It's kind of complicated for us to change uses [...] people have certain uses, we're working with them to change habits ... it's kind of hard. (E12)*
>
> *[...] we depend a lot [...] of the population, of their will to join groups. (E3)*

Some respondents identified the physical space as an obstacle to carry out health education activities, reflecting on the conception of what is health education for this professional.

> *The unit undergoing changes is difficult to perform health education, what is a waiting room, why there is not a waiting room yet, because it's all mixed [...] After the reform we will have waiting room and we can accomplish this health education better. (E13)*
>
> *What's lacking here is physical space, but our new facility is being built [...] [it will facilitate the health education activities]. (E9)*

On the theme of *Empowerment Concept*, it was divided into two sub-themes: *Community right* and *Unknowing the meaning of empowerment*.

In the sub-theme of Community right, the empowerment is seen as a user´s right of health services. Some reports illustrate this consideration:

> *Empowerment would be the rights of the user? In health? (E1)*

What I think, because I do not know what is empowerment, it is the person knowing what are their rights, what is his power, what he knows about health, what he knows of education, so there are the rights of the person, it is to be aware of it. (E14)

The community today is more participatory, it has to know their rights, it is seeking more rights and duties [...]. (E2)

Some reporting units state that the health worker identifies a relationship between empowerment by involving the community in popular participation and social control.

Be putting the community in participation of the PSF [...]. (E4)

[...] it iss the cooperation of the community along with us in the health care project, education, you know, and neighborhood improvement. (E19)

The community interact with the health [...] It is the community interacting with the healthcare team, trying to help each other, both sides, trying to put together, something that is also very difficult to happen. (E6)

In the sub-theme Unknowing the meaning of empowerment, there are the reporting units showing the ignorance explained by health workers with regard to the term empowerment. Some of them are even curious to know the true meaning of the term. Some reports express registration units that make up this sub-theme:

[...] I did not understand the meaning of empowerment, then there's no way I respond by not knowing the word. (E5)

I do not know, I do not know what is empowerment. (E7)

I do not know what it is that word, empowerment [...]. (E12)

Some registration units associate empowerment with the idea of acceptance:

Empowerment, I do not know what is empowerment. Would it be acceptance? (E12)

I'll tell you I do not know what that word is, I have no idea, but it could be that [referring to the acceptance of the population to the information received]. (E12)

The theme *Linking Health Education and Community Empowerment* reveals that respondents believe that consists of actions that complement each other. The reports bring the user as a subject who needs to be educated and informed by health workers to be able to manage to develop self-care. Some excerpts better exemplify this theme:

[...] Once you educate the population, it can feel more encouraged, more empowered, to take care of itself, take care of their health. (E3)

It has [relationship between health education and community empowerment] it is directly related.

[...] An enlightened population can discuss with us [...]. (E8)

DISCUSSION

The reports of respondents direct to a conception of what is health education for the workers. This is a linked process verticalized focused on guidance to users and which focuses on a priori concerns in conveying information and spend some predetermined content.

However, health education consists of a guided process in the construction of knowledge. For this, it is necessary to use a set of practices that aim to contribute to the users of health services regarding increasing their autonomy to self-care, and the link between these professionals and managers of health services.[16]

When building knowledge, it starts from the principle that all representations involved in the educational process are articulated as to identify them as part of the whole, that is the development of a thematic being worked in health education should be elected through the participation of all individuals involved in the process: health workers, users and managers.[17]

Moreover, there are actions focused on verticalization of relationships not contributing to the transformation of reality. When taking health education as a right to be exercised by the users, it should be ensured to provide the emancipation of the individual, ensuring their autonomy, and from then on, they will judge on health decisions regarding self-care, their family and community.[18]

The use of educational strategies that consider prior knowledge of the subject have already been identified as efficient in the teaching-learning process.[4,19,20] Also, successful tactics are seen as those that put individuals as co-authors involving them and the working method.

The concept and action on health education brought by health workers of this study refer to the doctrinal principle of the nineteenth century called hygienist and can be identified the great influence that it has in health practices still employed today.[21] This principle assumes that health education is an immediate response to identified problems to transforming the environment through authority postures.[22] Other studies also have shown the problems of perception of health professionals regarding health education still centered in offering courses training and

lectures linked to a bank education and little problematized.[23,24,25] Also, they show as difficulty, bringing the user to the educational process, getting their attention and the lack of a physical space suitable for the execution of activities.[23,25]

There is still a need to realize that the "act of educational way" not depend on a specific physical space and can be executed at all times of the health professional, for example, when to vaccinate a child, in clinical practice in sample collection, home visits among other places where these professionals circulate in their daily life.[26] Also, it is a replicated experience historically, from the training process, where the relationship between education and the tools used to put it into practice refer to the banking system, that is the transmission of knowledge, when one of the subjects is the holder of knowledge and transmits the information to the other subject who, until that moment, was "unknown".[26-27]

From this professional attitude, it is difficult to empower users of the public health system, especially to the exercise of social control. It starts from the assumption that the empowerment is directly related to the possibility of individual emancipation and formation of the collective consciousness. Therefore, the use of vertical strategies in health education probably will not be able to form critical individuals, reflective and who can effectively interfere in decision making towards improvement of health conditions of the popupation.[3,4,28]

However, understanding empowerment as a right to health and, at the same time, such a term being unknown by other professionals, highlights the mismatch in the process of training and continuing education of these workers.

A permanent health education consists of a practice capable of transforming and discussing the reality experienced by health professionals, focusing on the daily lives of services.[29] Naturally, in times of permanent learning is that the situations come to the fore, needing to be placed in evidence and problematized so that the team can reflect on what they do, listing potential changes that culminate in improving the care and health work process.

The idea that the permanent learning can be used as a leveling device of health services is not supported. Even to understand that they have their peculiarities that even are linked to loco regional conditions that are situated.[30] However, they will be principles or objectives that are confluent, meaning they can be as a "starting point" in direction health practices of that particular health district or municipality and continuing education may be able to strengthen them.

These principles shall be directly related to the guidelines of the Unified Health System, and unconditional knowledge by the health professionals, requirements for action in public health services.

CONCLUSION

The study provides evidence that the hegemonic model of education in health is traditional, guided in vertically guidance to users, not considering the life histories and their different knowledge. Also, there is a strong tendency to pass on information and not rebuild meanings collectively, not providing the user being part of the construction process and planning of educational activities.

They have been fragmented, punctual and carried out at certain times, such as educational groups or waiting rooms. There is a shared culture that health education should have a specific time to happen, being distanced from assistance. It is like one more activity to be made in daily life and not an aspect or a dimension that permeates all health worker actions.

Educational practices in the health services have not favored for community self-care instrumentation and even the development of the autonomy of the subjects, either, the process of promoting social control in health. Some of this may be the result of the process of training of health professionals, still being in uni-professional dimension and little purposeful to observe a change in professional attitude, able to have a horizontal care planning and causing users to be part of this process. Another part highlights the continuing education process currently in place in public health services and not reaching the goals set by the National Policy of Permanent Health Education.

This study does not have the pretension of exhausting the discussion and scientific literature about the discussed issues, showing the need for investigations that have the sensitivity to show possible ways and/or directors paths towards the exercise of a health education that is capable of empower users of the public health system reaching even the effectiveness of social control.

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