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ORIGINAL ARTICLE

HEALTH EDUCATION UNDER PERSPECTIVE OF FAMILY HEALTH TEAMS USERS

EDUCAÇÃO EM SAÚDE SOB A ÓTICA DE USUÁRIOS DAS EQUIPES DE SAÚDE DA FAMÍLIA

EDUCACIÓN EN SALUD BAJO LA PERSPECTIVA DE USUARIO EQUIPOS DE SALUD FAMILIAR

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ABSTRACT

Objective: to analyze the health education activities carried out by the professionals of the Family Health Strategy (FHS) from the perspective of users. ***Method:*** a descriptive, exploratory study with a qualitative approach. The production data was held in 2012 through semi-structured interviews with 20 registered users in the FHS teams in a city of Bahia interior. Data were organized based on the analysis of technical content, thematic modality. ***Results:*** users have shown lack of health education activities carried out by the teams of the FHS; made explicit is essential to carry out educational activities directed to their health demands and said it does not participate proactively educational activities. ***Conclusion:*** there is the need to carry out health education activities in the perspective of comprehensive care. ***Descriptors*:** Health Education; Family Health; Understanding; Nursing.

RESUMO

***Objetivo*:** analisar as ações de educação em saúde realizadas pelos profissionais das equipes da Estratégia da Saúde da Família (ESF) sob a ótica dos usuários. ***Método*:** estudo descritivo, exploratório, com abordagem qualitativa. A produção de dados foi realizada em 2012, por meio de entrevista semiestruturada com 20 usuários cadastrados nas equipes da ESF de um município do interior baiano. Os dados foram organizados com base na técnica de Análise de conteúdo, modalidade temática. ***Resultados*:** os usuários demonstraram desconhecimento das ações de educação em saúde realizadas pelas equipes da ESF; explicitaram ser imprescindível a realização de ações educativas direcionadas às suas demandas de saúde e referiram que não participam proativamente das ações educativas. ***Conclusão*:** ressaltamos a necessidade da realização de ações de educação em saúde na perspectiva do cuidado integral. ***Descritores*:** Educação em Saúde; Saúde da Família; Compreensão; Enfermagem.

RESUMEN

Objetivo: analizar las actividades de educación sanitaria llevadas a cabo por los profesionales de la Salud de la Familia (ESF) desde la perspectiva de los usuarios. ***Método:*** estudio descriptivo, exploratorio con enfoque cualitativo. Los datos de producción se llevó a cabo en el año 2012 a través de entrevistas semiestructuradas con 20 usuarios registrados en los equipos de la ESF en una ciudad de Bahía interior. Los datos fueron organizados en base al análisis de contenido técnico, modalidad temática. ***Resultados:*** los usuarios han mostrado falta de actividades de educación sanitaria llevadas a cabo por los equipos de la ESF; explicitado es esencial para llevar a cabo actividades educativas dirigidas a sus demandas de salud y dijo que no participa de forma proactiva las actividades educativas. ***Conclusión:*** hacemos hincapié en la necesidad de llevar a cabo actividades de educación sanitaria en la perspectiva de atención integral. ***Descriptores*:** Educación para la salud; Salud de la Familia; Comprensión; Enfermería.

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INTRODUCTION

The historical trajectory of health education has been built from the development of the public health field as a health practice in Social Medicine and Public Health, in Preventive Medicine and is currently referenced in the health promotion proposal in the international and national contexts.[1]

In Brazil, for several decades, health education was limited to hygiene education, in order to control and prevent diseases, as a normalizing practice. However, the creation of the Unified Health System (SUS) established health education as a set of practices with the potential to stimulate the autonomy of people, from the incorporation of educational activities in the routine of health services.[2-3]

In 1994, the Family Health Program was established, which later became known as the Family Health Strategy (FHS), and brought between the common tasks for all team members the conduction of health education activities to the enrolled population, valuing participation of users and health professionals involved in the process.[4]

Considering the particularities of the FHS, health education is one of the actions essential in the work process of health teams, and aims to share knowledge between health professionals and users, so that they can be encouraged to take critical awareness of themselves and the world.

Health education, as a tool for the emancipation of the subjects, should involve in their teaching practices elements such as dialogue and participation, which are established from the relationship between health professionals and users. In this sense, health education could boost the autonomy and active participation of subjects, considering that its main purpose is social transformation and consolidation of SUS guidelines.[5-6]

In the health promotion context, there is an urgent need to consider the Social Determinants of Health (SDH) in the development of educational activities in the perspective of explaining the social determination of the health-disease process, from the picture of social conditions in which people live and work.[7]

It also requires knowledge of the health needs expressed by disease, shortages, risks, vulnerabilities and projects or ideals of health that can be supplied by the inter-agency coordination and also the health care needs met by the use of services in the health system. Moreover, the development of social and language skills, enable these needs are expressed in terms of demand or request, individual or collective.[7]

Demand, as well as the right to health, express renovating conceptions of meanings and voices of the people placed in a social and historical context, being socially constructed and related to the health service profile, the relationship between professionals and users, and how to produce the care.[8,2] In this perspective, comprehensive care requires a critical reflection on the characteristics of the processes developed in the health services, considering that the fragmentation in the practices of professionals and how to organize their actions, which can lead to weakness in identifying the demands of users and therefore the forms to meet these demands.[8]

The lack of knowledge on health education is also related to the enhancement of health demands of users, flexible schedules, themes suggested by these and the use of problem-based pedagogy, so that the production of knowledge regarding educational strategies encourage the participation of users and possible changes in their free form of behavior and conscious.[9] Therefore, it is necessary that health education activities are not limited to the transfer of information, but to enable significant changes in how the person fits into the process of taking care of own health as a subject capable of producing changes that encourage exercise citizenship.

This study has relevance to raise reflections on health education activities carried out by the FHS teams, from the understanding of users as well as boosting the (re) targeting the practices of health professionals in order to glimpse the user co-responsibility in the care of your health.

The term *user* refers to people who receive the services offered by the health system, both the basic health unit to the hospital, whereas using the health system constitutes right of the population and duty of the State.[10]

The study aims to analyze the health education activities carried out by the professionals of the Family Health Strategy from the perspective of users.

METHOD

This is a descriptive, exploratory study with a qualitative approach, conducted with 20 users of the Family Health Units (FHU), in a municipality of Bahia's countryside. For the selection of FHU inclusion criteria were established: complete skeleton staff,

according to the criteria recommended by the Ministry of Health; teams with 80% to 100% of the registered and accompanied families; FHU with two teams; in which teams were not being developed the Education Program for Working for Health (EPW) of the Ministry of Health, whereas in general, teams executing this program conduct educational activities.

Study participants were selected from the following inclusion criteria: aged over 18, registered and monitored by the FHS team for the minimum of six months. It is noteworthy that the representative sample of the study was obtained from the saturation criterion that allowed the depth and breadth of understanding of the phenomenon studied.

The profile of the participants was characterized by people aged between 19 and 64 years, 19 female and one male, with education ranging from incomplete elementary school to university. Most exercised the profession/occupation of the home and the other, driver, housekeeper, secretary, public and autonomous employee. As regards the residence time in the coverage area USF was eight months to 32 years with registration time from six months to 11 years.

Data were collected through semi-structured interviews, recorded in a private place in the USF, from April to May 2012. The analysis was performed from the content analysis technique, thematic modality. Concurrently with the data collection, it started the pre-analysis was the first step of the analysis, proceeding to the choice of documents that would be analyzed based on the proposed objectives, contemplating the transcription of 20 interviews. Subsequently, the initial reading of the collected material was carried to the constitution of the corpus aimed at your organization.[11]

In the second stage, there was the exploration of the empirical data with coding operations, establishing the registration units in order to discover the units of meaning inherent in the words that appear frequently.[11]

In the third stage, it performed the treatment of the results and their interpretation in order to make them meaningful and valid. Then it moved on to categorization, providing a simplified representation of the raw data[11], and thus emerged two categories: health education actions: gaps in the context of family health and participation in educational activities: sharing knowledge?

Informants were identified in the text by a number corresponding to the ascending order of the interviews – interview nº 1, read it, E1, and so on.

The research project was submitted to the Ethics Committee of the State University of Southwest Bahia and approved by the opinion under nº 7765 of March 20, 2012, CAAE: nº 01275812.2.0000.0055 and participants signed the consent form clarified fulfilling all ethical requirements of the Decree 466 of December 12, 2012.

RESULTS AND DISCUSSION

Category 1 - health education Actions: gaps in the context of family health

Health education practices allow the empowerment of the individual to the self-care, as a strategy for decision-making with critical awareness by emphasizing the social, cultural and economic context in which is inserted a grounded dialogue is possible and planned for presented particularities[12]. However, the study showed ignorance of users about the health education actions:

[...] No, I never heard of [...]. (E6)

[...] I do not understand [...] come more when it is for medical consultation [...] I do not come because they do not give importance. I have no idea of the importance [...]. (E13)

From the reports, it is emphasized that the lack of health education actions in the FHS may cause difficulties for the understanding of the importance of these actions. This finding confirms the position found in the literature that health education can be considered as a relevant practice to be integrated into health care, besides serving information, it also suggests exchange of knowledge and awareness on alternatives for the prevention of disease and promoting the health of individuals and the community, and the lack of knowledge about the transformative potential of health education can prevent individuals from experiencing improvements in their quality of life and the community.[12]

The report of E13 shows a biologicist view when relating the medical consultation main purpose as to contact the health service.

Respondents highlighted that it is essential to carry out more dynamic educational and directed to their health demands:

[...] In this area [educational activity] have to talk very little, because they leave also want [...] shares some fall short [...]. (E2)

[...] I miss because it has not, here not lectures, and should do [...] have to invest more in it for people to become more aware, take better care, better to prevent [...]. (E7)

[...] I think it would have to have [...] waiting room [...] would be useful because [...] we come and is troubled, sitting here on this bench [...]

this orientation should be in an organized way [...]. No use putting a poster, no one reads [...] sometimes put flyers up there, but the staff did not handle [...]. (E8)

[...] Already attend four years ago, I did not hear guidance [...]. About breastfeeding was [...] in the hospital [...] I had guidance. (E10)

The reports of respondents show that professionals from the FHS teams do not develop educational activities, which seems to be related to the fact that these do not seize the opportunities of meeting with the user of the health service to incorporate in their everyday practices, educational activities that value interaction, restricting themselves to specific activities, such as the use of posters and leaflets without context with the reality of these users.

Respondents also mentioned that they miss the lectures that encourage prevention and health care, orientation in an organized way, taking advantage of every meeting spaces with the user.

The practical caregivers need the reflection of the ways of knowing/doing, so that the arrangements are concrete in the daily work of teams[13], although this view is not present in the studied reality.

It was also possible to identify which health promotion actions that should be offered by the FHS teams have been held at the secondary level of health care, a fact that points to the lack of health education actions, whereas these should occur from primary care and were held only in hospital care.

It is understood that from the moment that health education activities are not carried out in primary care may be discontinuity of health promotion and disease prevention, which seems to contribute to the increased demand for hospital.

The FHS should be seen as the gateway to the SUS, with the purpose of a new dynamic, by defining responsibilities not only of health professionals, as well as the population. Thus, the actions must be planned collectively between these social actors, providing the establishment of a bond and co-responsibility, as a result of appropriate and effective forms of health actions.[14]

Some informants related health education activities to specific topics, targeted to certain population groups.

[...] I understand that it would be guidance given by the professionals of health directly or indirectly [...] the specific areas of health [...] pregnant, hypertensive, diabetic [...]. (E8)

[...] These activities [...] is to enlighten people seeking health clinic on diseases, family planning [...]. (E10)

[...] It is very knowledgeable about everything we should do during pregnancy and after child birth. (E14)

The educational actions, in the study's users point of view, are more punctual, focused on specific health areas of women, child health and clarifications on diseases with emphasis on hypertension and diabetes mellitus. These reports reaffirm the hegemonic medical model, producer of procedures to population groups, which makes comprehensive care.

In this direction, the centrality of health production with an emphasis on procedure favors that users have the opinion that this is the way for the construction of care. Thus, this perception of the health service by users, as well as by health professionals, is built from subjectivity processes, and organizes and operates an imaginary demand for procedure to replace the demand for care.[15]

This demand is centered on the logic of offering procedures, and seems to distance themselves from DSS that should be considered in the health-disease. Besides, the users fail to realize the transformative character of these health education actions.

Thus, health education enables the exchange of knowledge between users and between users and professionals, and respecting freedom of expression, in which subjects take their significant roles. Thus, the educational process is expressively and with the capacity to bring about change, because the subjects are able to express desires, feelings, being able to re-invent different ways of life and social organization.[5]

In this perspective, individuals and families should be assisted before the emergence of problems and harm to your health. For this, the FHS teams should act in order to expand and strengthen popular participation and of personal and interpersonal development process, in which professionals must be available to interact with the users of this service and the commitment to use educational practices as therapeutic tool and to promote health.[16]

In the study, the FHS users seem points out that the educational activities carried out by the health team are focused on prescription treatments, behaviors and behavioral changes, which favor the transmission of knowledge, demonstrating the absence of any other health education strategies, beyond the lecture.

[...] Explain how we should act, what we should do, what to eat, what not [...]. (E3)

[...] The talks [...]. (E5)

[...] It's about power, passing by the doctor [...] take the right medicines [...]. (E12)

These accounts show a prescriptive posture of health professionals by developing educational practices, showing users what should and what should not be done, which does not seem to value the dialogue and interaction with these in order to understand the expectations to their health needs.

It is understood that the educational practice that favors the transmission of knowledge does not awaken the critical and reflective potential users of health services, regarding to their integration into the world, as historical and social subject. In this context, health education should consider the health demands and the potential of these users, aiming to collectively build proposals for educational activities consistent with the reality experienced by them.

It is essential that health professionals encourage dialogue, listening and development of health education practices that raise benefits to staff, members and family.[13]

The behaviors of individuals are guided by their beliefs, values and representations of the health-disease process, requiring consideration of psychosocial and cultural determinants in health behaviors. Therefore, should be avoided in educational practices the vision of users as object and lacking in knowledge about health.[17]

In this perspective, the pedagogy of questioning allows considering the historicity of people, recognizing them as unfinished, unfinished, and in a historical reality, it is also unfinished and, thus, educational practice is remade in the praxis as action- reflection-action.[18]

Thus, health education should encourage greater participation of users of health services in order to contribute to the knowledge of the reality in which live together and share knowledge and experiences in order to provide better quality of life through actions that aim not only the transmission of knowledge, but stimulating social participation.

It was also shown that the educational activity is performed in some situations, for health professionals who are not in the team: "[...] when someone comes and says, comes more people out because the post is even more difficult [...]. "(E4)

Users seem to identify the need for health professionals conduct educational activities and indicate that in general, these are performed by professionals who are not included in the health teams.

It should be evident that all health professionals should carry out educational actions in health and daily effective way in order to ensure the character of health promotion, with proactive participation of users.

Among the health education purposes there is the use of innovative practices through dialogue that works as an educational approach. This approach enables the exercise of transformative learning by individuals and community to build skills and attitudes to criticism of health decisions in personal and collective development.[5]

On the other hand, it was identified that the nurse used dialogue and active listening to promote care for the user through their health demands, boosting this act proactively in the process of taking care of health.

[...] She [nurse] also explained the importance of prenatal care, control the pressure to not have eclampsia in delivery time [...] healthy foods for pregnant women. [...] I learned a lot [...] what a mother needs to know about your baby's health [...]. When I had my doubts I came to her and asked [...]. If I got pregnant again was ready to have my baby [...] was very important to me [...]. (E19)

The nurse has the opportunity to exercise the technical and scientific knowledge allied to relational technologies, especially if it is shared with other team members, a fact which could provide new ways to provide care, increasing the user's relationship with health professionals, greater satisfaction and, thus, more active participation in group decision making.[19,4]

Health education is configured as an essential part of the nurse because of possible dialogue between the different elements involved, and enhance changes or adaptations to new life situations.[20]

The construction of a critical consciousness of professionals and users about the social reality and the limits and possibilities of each with own health is generating empowerment. This is due to the participation of the subjects through dialogue in order to contribute to the construction of identities and critical and active subjects.[5]

Category 2 - Participation in educational activities: knowledge sharing?

Respondents said they do not participate in health education activities, considering that these actions are held at times that do not match to their availability.

[...] On the lecture were never call me [...] direct work, but tell me I could even ask for a break and come. At least the high pressure, hypertension, could watch to stay inside, what can, what you cannot do [...]. (E6)

[...] I do not come because sometimes it occurs when we are working [...]. (E16)

[...] I was never invited [...] why I never came [...] if I knew I would [...]. (E18)

This reality portrayed by the interviewees refers to the analysis of the importance of professional health teams develop strategies to ensure users' access to health education activities ensuring greater participation and appreciation of these actions.

For FHS users to seize the guidelines and act in conjunction with the health team in action planning, it is necessary to realize the need for shared knowledge, aiming to understand the purpose of educational activities.[21]

In this sense, the educational activities developed by health professionals should be set up on opportunities to encourage the participation of users effectively, expanding look at the DSS and the uniqueness inherent in comprehensive care. In addition, there is an urgent need to develop strategies to ensure the participation of users based on the reality experienced by them, with wide dissemination and adaptation of hours of educational activities.

In turn, it was found that some of the users of the FHS reported the motivation of the health team professionals. However, they do not participate effectively in educational actions:

[...] Do their activity [Community Health Agents - ACS], invites us to come [...] it is because I myself do not like to come [...]. (E15)

[...] Will [ACS] in the house of each family, speaks what subject will be treated, but people who do not come [...]. (E16)

[...] I have heard, but never came in health education activities carried out by the family health team [...]. The community agent has invited me [...]. (E17)

The reports of the respondents seem to provide that they fail to realize the importance of educational actions developed by professionals from the FHS teams, considering that, despite the motivation by the ACS, they do not participate in the actions proposed.

On the other hand, when professionals determine the topics to be discussed, they seem to indicate that not always contemplate the users' demands, considering they were not agreed through dialogue. Thus, the lack of interaction between the user and the health service cannot produce subject, stimulate their autonomy, plastering it to the logic of dependence on procedures.[15]

Furthermore, by having greater knowledge of the reality of families in your micro-area, the ACS acts as a link between health professionals and the community, since it lies in the area of operation and conducts home visits daily, giving a view of the user inserted within the family, and the opportunity to participate from the planning to the realization of educational activity consistent way with the local reality.[4,22]

From this perspective, health education actions should promote greater participation of health services users, providing integration between their health needs and the issues addressed.

Some respondents reported how is their participation in educational activities:

[...] Only participate, never took doubt [...] never asked a question [...]. (E3)

[...] My participation is much more to listen [...] I am not to talk [...]. (E10)

[...] My participation is more listening [...]. (E12)

Reports show that user participation in health education activities does not occur proactively, since they do not express their doubts and experiences and do not use dialogue as a means of construction and/or reconstruction of new knowledge.

Health education should not be normative, prescriptive and focused on the health professional, but a continuous movement of dialogue and exchange of experiences, which is intended to articulate individual and collective dimensions of the educational process, for the understanding of the person as someone who has knowledge and not as a mere receiver of information.

It is essential to listen to the users so that they feel inserted proactively in the actions carried out by health professionals, which could help to meet the health demands of users, enabling the planning, evaluation and redirection of these actions.[22]

The challenge of dialogic health education requires, on one side, an effective change in the attitude of professionals and, on the other hand, requires institutional conditions conducive to professional's understanding of the intersubjective character of ideas and practices on health and quality of life as the development of a communication, in which there is genuine interest by the senses and feelings mobilized on user experiences.[1]

Thus, there should be not only the learning techniques and communication skills, but

mainly the emphasis on the transformation of values, beliefs, worldviews and subjective measures by professionals, without ignoring the context in which they are realized.[1]

Health education, based on questionable methodology, tends to propose the construction of shared knowledge between individuals through dialogue, and a way of approaching the educational practices of the population's needs is seeking the active participation of these subjects,[20] so, it is possible to involve professionals from the FHS team and subjects in the survey of problems and health needs, through reflection and identification of interventions necessary for solving health problems according to real needs, considering that, at the first moment, the professional leads discussion with a thematic approach suggested by users and encourages discussion on the premise of the emergence of previous knowledge and later will be suggested and discussed ways of coping to improve the quality of life.[20]

In this direction, some users have reported their participation in educational activities clarifying doubts and seeking information on issues related to health.

[...] Speak [...] ask [...]. (E4)

[...] clarify many doubts , ask it, all I want to know [...]. Because I like to be always informed [...]. (E14)

The design of health education in a emancipatory way for the professional and the user implies increasing the ability of people to understand health in its entirety. Thus, it is made possible critical awareness to the autonomous decisions of subjects, thus contradicting the uncritical acceptance of certain norms.[5]

Health education allows the expansion of the user link to the team through spaces of production and application of knowledge. Thus, in the care production activities, there is a continuous exchange of knowledge among users of USF and the team, with an exchange of teaching and learning among all involved.[23]

New ways of acting and producing care implies the appreciation of the uniqueness of users and enables interpersonal relationships to have a structural role in the production of comprehensive care, and raise the construction commitments and co-responsibility between health staff and users.[24]

FINAL REMARKS

The present study identified that some respondents revealed a lack of knowledge about educational practices carried out by the FHS professionals. Also showed that some health education activities do not denote interaction between these users and health professionals with specific issues approach for certain population groups, and emphasis on the transmission of knowledge.

Besides, the results showed that some FHS professionals develop educational activities centered on the hegemonic medical model, which requires the reconstruction of their professional practice, which sometimes seems to bring embedded production procedures at the expense of more relational approaches, compromising the production of total care.

In turn, FHS users also pointed that educational actions permeated by listening and dialogue, which contributes to healthy ways to take care of health.

This work also highlights the role of health professionals in relation to encouraging the users participation in educational activities, enhancing the ACS as a motivator for their participation in the proposed actions and the nurse in the construction of shared knowledge.

To reach more effective results in the educational activities, it is necessary that the professionals use such education based on health demands presented by users, so these actions can take place in the closest way of life context of these.

Thus, the educational activities developed by health professionals may constitute mobilization strategy of the users' social, political and ethical potentials, to act politically as citizens – as social subjects who participate in the construction of their own history.

The study reached the goals, however, presented as limitations reality of a Bahian municipality, preventing generalization of the results to other settings, which raises the need to conduct further research to explore health education in view of users of the FHS, revealing other perspectives and scenarios not covered presently.

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