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ORIGINAL ARTICLE

SHARING OF SELF-CARE KNOWLEDGE AND MEDICINAL PLANTS FOR URBAN AND RURAL SCHOOLCHILDREN

COMPARTILHAMENTO DE SABERES DE AUTO ATENÇÃO E PLANTAS MEDICINAIS PARA ESCOLARES URBANOS E RURAIS

COMPARTIR SABERES DE AUTOATENCIÓN Y PLANTAS MEDICINALES PARA ESCOLARES URBANOS Y RURALES

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ABSTRACT

Objective: to know how the sharing of self-care knowledge takes place in the context of urban and rural schoolchildren and the relationship with medicinal plants. ***Method:*** qualitative, descriptive, and exploratory study conducted through a semi-structured interview recorded at the home of schoolchildren of urban and rural areas and analyzed through an operational proposal. ***Results:*** general and specific self-care actions are present in the school, but in a punctual manner and usually worked by the teachers. The gap between professionals from schools and health services reinforces the growing need for articulation between these sectors. There were no significant disparities between the urban and rural population. ***Conclusion:*** it is necessary to rethink the teaching strategies, the concept of health adopted, and the articulation with other sectors and even between the school subjects in the school context. ***Descriptors***: Knowledge; Plants, Medicinal; Culture; Health.

RESUMO

Objetivo: conhecer o compartilhamento de saberes de autoatenção em saúde no contexto de escolares do meio urbano e rural e a relação com as plantas medicinais. ***Método:*** estudo qualitativo, descritivo e exploratório por meio de entrevista semiestruturada gravadas no domicílio de escolares do meio urbano e rural, analisados por meio da proposta operativa. ***Resultados:*** as ações de autoatenção amplas e restritas estão presentes na escola, entretanto de maneira pontual e trabalhadas geralmente pelos professores. O distanciamento entre os profissionais da escola e dos serviços de saúde reforça a necessidade crescente de articulação entre estes setores. Não houve disparidades significativas entre a população urbana e rural. ***Conclusão:*** é preciso repensar as estratégias de ensino, o conceito de saúde adotado e a articulação com outros setores e entre as próprias disciplinas no âmbito escolar. ***Descritores:*** Conhecimento; Plantas Medicinais; Cultura; Saúde.

RESUMEN

Objetivo: conocer el compartir saberes de autoatención en salud en el contexto de escolares del medio urbano y rural y la relación con las plantas medicinales. ***Método:*** estudio cualitativo, descriptivo y exploratório por medio de entrevista semi-estructurada grabadas, en domicilio de escolares del medio urbano y rural, analizados por medio de la propuesta operativa. ***Resultados:*** las acciones de autoatención amplias y restrictas están presentes en la escuela, pero de manera puntual y trabajadas generalmente por los profesores. El distanciamiento entre los profesionales de la escuela y de los servicios de salud refuerza la necesidad creciente de articulación entre estos sectores. No hubo disparidades significativas entre la población urbana y rural. ***Conclusión:*** es preciso repensar las estrategias de enseñanza, el concepto de salud adoptado y la articulación con otros sectores y entre las propias disciplinas en el ámbito escolar. ***Descriptores***: Conocimiento; Plantas Medicinales; Cultura; Salud.

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INTRODUCTION

Health is a human right, just like work, housing, education, food and leisure. The school is a space where citizens of these rights are prepared through practices carried out by critical subjects, capable of developing actions that strengthen the participation of people in the search for health.[1]

Schools represent an important space for discussing and learning about health. Similarly the health system that still has as focus on the biomedical care model, the actions carried out in schools reflect this model, which is centered on diseases or their prevention. This way of thinking about health has been insufficient to make the school a space to produce health.[1]

Health content in basic education has often aimed merely at transmitting knowledge, where students learn to repeat, access, and use only specific sets of knowledge. However, an efficient and citizen training is one that allows the access to information in a way that the learners are able transform it into knowledge through critical and reflective thinking, according to their cultural reality.[2]

Thus, it is understood that the curricular policy is - or should be - cultural. The curricula should be formed by a selection of sets of knowledge consistent with the different ways of perceiving the world.[3]

This perspective directs the need for the schools to take into account the knowledge and experiences of the students, as for example in the issue of self-care in health. Self-care refers to the representations and practices that people use to control, facilitate, endure, heal, or avoid processes that affect their health, in real or imaginary terms. It involves deciding, in an autonomous or relatively autonomous way, how people will act in the search for health.[4]

It can be divided into two levels, the general and the specific. The general level consists in actions culturally established, including care and prevention of diseases, activities of food preparation, hygiene, and others. The specific level refers to the intentional practices applied to the health/illness/care process.[4]

Alternative or complementary practices have increased in capitalist and developed societies, both in the scope of general and specific self-care.[5] Thus, a way of discussing the different health knowledge sets in the context of self-care, including in the school environment, is to take into account the reality of the students, valuing their knowledge and culture, as in the case of knowledge about medicinal plants.

Furthermore, with so many changes in urban and especially rural identity [6], and particularly regarding actions and access to health, it is important to know the reality of the students in these two contexts in order to identify possible discrepancies related to cultural factors and to adapt the attention to this reality.

By doing so, considering the student as part not only of the school but also of a community and a family, it is necessary to understand him as a whole in order to identify how health issues, and especially self-care, have been worked out in these different contexts, taking into account their cultural reality.

OBJECTIVE

- To know how the sharing of self-care knowledge takes place in the context of urban and rural schoolchildren and the relationship with medicinal plants.

METHOD

This is a qualitative, descriptive and exploratory study linked to the research project entitled "*Use of medicinal plants and popular health practices among schoolchildren from a municipality of Rio Grande do Sul*", developed by the Nursing School of the Federal University of Pelotas (UFPel) in partnership with Embrapa Temperate Climate, funded by the Foundation for Research Support of the State of Rio Grande do Sul (FAPERGS).

The study was carried out at the home of the students, in the urban and rural area of the city of Pelotas (RS), in the vicinity of two schools, one in the 9th district, Monte Bonito, and the other in the Balsa district, Porto region.

The participants were 12 schoolchildren who were attending the 5th, 6th and 7th grades and 6th year. The schoolchildren are identified by fictitious names of medicinal plants, followed by age, sex (F or M corresponding to female or male, respectively), and area (urban or rural).

The selection of students was based on the following criteria: enrollment in the pre-established grades; having responded to the questionnaire of the above-mentioned research project; having mentioned in this questionnaire the use of medicinal plants; and having provided telephone contact.

The database of the Project "*Use of medicinal plants and popular health practices among schoolchildren from a municipality of*

Rio Grande do Sul" was consulted to collect data for the present study, specifically the answers to the question "Do you use medicinal plants?" All families of the schoolchildren who responded positively to this question were contacted. Up to three telephone contact attempts were made.

In the telephone contact, the reason for the contact was explained to the families of the schoolchildren and they were asked if they had interest in participating in the research. After the acceptance, a home visit was scheduled, in the shift that the child/adolescent was not in the school. Data were collected from January to July 2014. A semi-structured interview was used as a data collection instrument.

The research project was approved by the Research Ethics Committee of the Nursing School of the Federal University of Pelotas (UFPel) under protocol number 223/2011. The Resolution COFEN 311/2007 of the Code of Ethics of Nursing professionals which deals with teaching, research and technical-scientific production was respected in this research[7], as well as the Resolution 196/96 and 466/12 of the National Health Council of the Ministry of Health.[8-9]

The information was analyzed following the operational proposal of Minayo[10] from which emerged the category "The transmission of self-care knowledge for schoolchildren", which will be presented below, preceded by the characterization of the study participants.

RESULTS AND DISCUSSION

♦ Characterization of participants

Twelve schoolchildren were approached, six from the urban area and six from the rural area. The choice for these two different contexts aimed at learning their differences and similarities regarding self-care in health.

The age of the schoolchildren ranged from 11 to 15 years, and they were attending the 5th, 6th and 7th grades and 6th year in municipal schools. This age group is interesting for the investigation of issues involving culture because they are in a phase of life in which they begin to carry with them, besides the values of the family and the school, their own values, which are under construction.

♦ The transmission of self-care knowledge to schoolchildren

Education, as a universal right, has the school as one of the spaces for its practice. The school is also considered a social institution, since it does not only involve teaching, but also the formation of citizens and is considered one of the most important social milieux after the family.[11]

Schools are spaces of extreme importance for the development of knowledge of socially constructed contents, aiming at guaranteeing the autonomy of the population, besides gathering children and adolescents in an important period when critical stages of growth and development take place.[12]

Besides the school, the other environment that has a strong influence on the actions of children and adolescents regarding health issues is the family household. This is a unit that takes care of its members, serving as the main socializing agent of children/adolescents, and responsible for the formation of life and health references. In Brazil, the fact that the family household is a privileged environment for adequate human development is acknowledged in the Constitution and in the Statute of the Child and Adolescent.[13]

The family is usually largely responsible for the transmission of beliefs and values rooted in the culture, according to the peculiarities of the environment in which they are inserted. In this way, it is important to know in these two contexts how the self-care knowledge, so present in the family context, has been perpetuated. In this context, when students were questioned in the family environment about the health content addressed in the school, they mentioned the following aspects:

> *Human body, like vaccine, these things* (Transagem, 11, F, rural).
>
> *Yes. The teacher, that one,* [name teacher] *says that we have to eat normally, he says we cannot eat too much or too little. If we eat too much we get fat if we eat little we get weak, it gives anemia* (Carqueja, 13, M, rural).
>
> *The teacher said this about HPV* (Mint, 11, F, rural).
>
> *Yes, science and sometimes we learn about mouth health when the dentist goes there* (Fennel, 12, F, rural).
>
> *In the sixth* [grade] *the teacher [teacher's name] said a lot about hygiene, we even did a poster. And care about sex* (Boldo, 12, M, urban).
>
> *Ah yeah they speak about that, but it's more about diseases, like... Sexual diseases. They gave a lecture* (Chamomile, 15, F, urban).

Two schoolchildren (Palminha, 13, F, rural and Insulin, 12, F, urban) reported not learning anything about health at school. In this context, it is observed that health teaching at school involves general self-care actions such as hygiene, oral health and feeding, and specific actions such as those

related to sexually transmitted diseases. The teaching happens in a punctual way though, addressing isolated topics in single moments, and health issues are not part of the school routine.

This reflects on who is working with health at the school. The figure of the teacher was the most cited. However, these professionals do not have the critical training to work with health topics and, for this reason they are often influenced by pre-formed speeches related to the biomedical model of care. Indeed, it was observed that health professionals were very little mentioned; only dentists were mentioned.

In order to make health actions to become more present in the school environment and make them focus on disease prevention and, above all, health promotion, professionals in the area, including nurses, need to come closer to this context.[14]

Studies corroborate the discourse of the students herein, showing that health professionals have had limited involvement with schools, not being effectively part of the health education activities developed in these places. This sort of activity is not part of the daily life of health professionals, and occurs in a punctual manner. In addition, professionals have had difficulties to carry out creative and innovative actions, with participative methodologies, besides limitations in dealing with the demands formulated by students and the schools.[15]

Before this reality, fragmentation is obviously a situation experienced by teachers and health professionals, in which the former, fragmented into school subjects, usually work only what is pre-established and determined to them. And as for the health professionals, every day gradually more divided into different specialties, are especially concerned with the part of the body in which they have expertise. This fact demonstrates a need for a greater articulation between the health and education sectors, as well as within each of these areas.

In order to improve the articulation between the different spheres, i.e. education and health, a proposal of intersectoriality between school and health has been introduced since 2007 through the Health in School Program (HSP). This program foresees the constant articulation between services[16]. However, despite having been created ten years ago, the Program has not been effective.

The use of medicinal plants as a self-care practice is present both within the family and at school. Therefore, the students were questioned as to the origin of their knowledge on this subject in order to know if the school and the family are or not present in the transmission of this popular knowledge.

When questioned about the origin of their knowledge about medicinal plants, three students (Transagem, 11, F, rural; Palminha, 13, F, rural; Insulin, 12, F, urban) pointed to their mothers as their source of knowledge; one of them (Carqueja, 13, M, rural) pointed to the father; one pointed to the mother and the father (Marcela, 15, F, rural); two of them (Fennel, 12, F, rural; Anis, 14, M, urban) pointed to the grandmother; two of them mentioned the mother and grandmother (Citronela, 12, F, urban; Capim-cidrão, 11, M, urban); and two mentioned the school and a relative, such as school and the father (Boldo, 12, M, urban) and the school and the stepfather (Chamomile, 15, F, urban). One schoolgirl (Mint, 11, F, rural) mentioned several family members, such as her mother, father, grandmother, sister and neighbor.

Corroborating these results, studies have shown that the transmission of knowledge about medicinal plants occurs mainly in the family context. Furthermore, the female figures - mother and grandmother - are the ones who are most referred to as holders of knowledge within the family.[17-18]

On the school context in which the topic of medicinal plants is discussed, four schoolchildren (Transagem, 11, F, rural; Mint, 11, F, rural; Carqueja, 13, M, rural; and Citronela, 12, F, urban) said these discussions happen through extracurricular projects at the school, such as the Federal Government Program entitles "More Education" and the "New Talents Project" developed by the Federal University of Pelotas (UFPel). Five schoolchildren (Palminha, 13, F, rural; Fennel, 12, F, rural; Anise, 14, M, urban; Insulin, 12, F, urban; and Chamomile, 15, F, urban) reported learning about the subject in the school subject "Sciences". With this, it was again verified that health professionals are not present, except for extracurricular projects.

In order for the health actions within the school to be able to integrate a citizen posture of the school, these should encourage personal and social accountability, the appreciation of culture, the perception of rights. For this, the fostering of autonomy should be the fundamental piece of this work[15]. However, the perceptions of the students revealed that health actions in the school, especially in the scope of self-care, occur in a punctual and fragmented way. This

fact reiterates the need for greater interaction between health professionals and the population, regarding different health practices.

In the context of the school vision, there were also no significant discrepancies between urban and rural schoolchildren. The only difference observed was that the two schoolchildren who referred the school as the source of their knowledge on medicinal plants were from the urban area. This is a contradiction because it was expected that children/adolescents in the rural area were offered contents more linked to their context such as the production and cultivation of plants. Thus, there is a context that involves a reduced use of medicinal plants over time and family generations, and several are the influences.[19] The biomedical model is one of the influent factors, although not the only one. The school is also part of this reality, what was indicated by the fact that "medicinal plants" have not been sufficiently explored in either of the environments, urban or rural.

There is a need for greater approximation between the values of the children/adolescents and those of the school in order to legitimize their actions of self-care in health. On the other hand, it was observed that the children/adolescents end up reproducing speeches heard at the school to the extent that the forms of care practiced within the families are not reinforced in these educational institutions.

By observing the analyzed aspects, one possibility to solving these fragilities would be to rethink the school education and to include the reality of the students in the political pedagogical project, and with this, the appreciation of popular knowledge, largely ignored at the present situation. To this end, a greater expression of schoolchildren should be stimulated, leaving the predetermined plan aside, so that this may even become a way for the youth to be responsible for the continuity of popular knowledge, sometimes lost in the family generations. It has also been observed that extracurricular activities have somehow filled these gaps, and they can represent a promising path for this change in the way of working health and education jointly between different sectors.

CONCLUSION

It was possible learn how the sharing of self-care knowledge has taken place in the context of urban and rural schoolchildren and its relationship with medicinal plants. The discourses of the students reveal that the actions of self-care, either general or specific, are present in the school, but in a punctual manner and usually worked by teachers.

In the family context, schoolchildren report that the mothers and grandmothers are the main responsible for transmitting knowledge about medicinal plants. In the school context, Science teachers are the ones who most deal with the subject. However, it is evident that the theme is worked from the biomedical perspective of health, because according to the information provided by the students, the content address diseases, the human body, hygiene, and vaccines, among others. This reality is also not so different in the case of the actions of health professionals, who were little mentioned in this study. These results demonstrate that professionals have difficulties in understanding that health can be discussed outside health services.

The gap between professionals from schools and health services reinforces the growing need for articulation between these sectors. The proposal of intersectoriality defended by the HSP needs to be better discussed and integrated to the school curriculum, with the support of health professionals.

The theme of medicinal plants, which integrates the cultural reality of schoolchildren, is addressed in the school by Programs/Projects that seek an approximation between the local culture and several sectors.

There were no significant disparities between the urban and rural population. The only discrepancy observed was that only urban schoolchildren referred to school as a source of knowledge about medicinal plants.

Despite the limitation of having analyzed the reality of only two schools, it was possible to verify that the school is a privileged space to form autonomous citizens who are aware of their conducts. In order to achieve this goal, it is necessary to rethink the teaching strategies, the concept of health adopted, and the articulation with other sectors and between the school subjects. The development of critical and reflective citizens is conditioned to a Dialogic training, culturally sensitive and interfaced with several fields.

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