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Original Article

Comprehension of Representations and Health Education Practices from Users and Professionals of the Family Health Strategy

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Abstract

Introduction: Education in health is a key part in primary care. Health education practices are often reproduced in the context of health in a thoughtless or even automated way, which are socially determined. In this context, users and team members tend to reproduce ways to "educate", which objectives, concepts and practices can be contradictory to the principles of SUS and to the subjects' values. Knowing the representations and health education practices can contribute to the adequacy of care. Considering the present time when both the training of health professionals such as SUS consolidation must converge in their principles and practices, this study is justified by contributing to the debate on the concepts and practices of ES in the context of the ESF**.** **Objective:** To understand the representations and ES practices between users and ESF team. **Material and Methods:** Semi-structured quantitative and qualitative research focused on interview techniques with the theory of Social Representations as a benchmark for analysis and participant observation. Seventy-five subjects participated in four groups: a) Higher-education professionals, five nurses, three doctors and one dentist; b) eight professionals with technical training in nursing and dental health; c) ten community health workers; d) forty-eight users of ESF units. Data were analyzed using content analysis, whose categories were retrospectively established. **Results:** "Education" as well social value, cultural to be preserved in the family; "Health" as individual self-care; "Health education" as transmission, prescription of body care. **Conclusion:** The principles of popular health education can support redefinition processes of the practices analyzed.

Keywords: Health Education; Public Health; Primary Health Care.

Introduction

As defined by the Ministry of Health, health education (ES) is a fundamental part of primary care in the Unified Health System (SUS). As a set of health practices, ES should contribute to the autonomy of individuals in their care and dialogue with public health workers and managers to meet their needs. From the perspective of Popular Health Education as a state policy, it should promote popular participation, participatory management, social control, care, training and health education practices [1].

The official definition is comprehensive, but it is necessary to emphasize the exercise of popular participation for social control, a doctrinal principle of SUS, which should not be limited to health care.

In this context, ES needs to cover the dynamics of life in the community with the identification of health problems, the means and appropriate ways to face them in the context of society [2].

The redefinition of principles, objectives and practices of ES need to consider the different social actors in this process, including its social space. In this sense, recognition, mobilization and incorporation of social movements play a key role in the evolution of educational principles and ways of conducting ES, with successful experiences in popular education movements [3].

In Brazil, traditional ES may be considered hegemonic and tends to reproduce an authoritative pedagogy, common in the educational practices of the different professional categories. It is based on technical and scientific knowledge to educate people to control diseased individuals and prevent diseases. This ES conception and practice is highly prescriptive and individualized, blames the patient for the illness acquired and disregards the social determinants of health. It has historical determination, being hegemonic in the training of professionals is also reproduced in the working world [4,5].

As an alternative to traditional practices, popular health education (EPS) assumes that the learner, regardless of position he holds or role he plays, is an active subject of the learning process, bringing to the field of ES meanings and values of the social context [4.6].

This conception of ES points to the need for changes in the practice of health professionals to beyond the imposition of habits and behaviors prescribed in an authoritarian and decontextualized form values and needs of individuals. Although it associates ES to the set of health practices, it presumes the overcoming of traditional health education practices [6].

This study shows EPS as a theoretical framework to analyze representations on ES. This option is justified because it is the National Policy of Popular Health Education (PNEPS), a recent policy of the Ministry of Health but legitimized by a social movement that made history in Brazil, being active in different regions [4,7].

EPS has five principles: a) to listen; b) to remove the magical view; c) to learn / be with the other; d) to consider the ingenuity of students; e) to live patiently impatient. It is noteworthy that the recognition of popular knowledge as a starting point of the health education process is a considerable challenge in the health field, historically marked by positivist scientific knowledge [5].

Considering the present time when both the training of health professionals as the SUS consolidation must converge in their principles and practices, this study is justified by contributing to the debate on the concepts and practices of ES in the context of ESF. The aim of this study was to understand the representations and ES practices among users and the ESF team.

Material and Methods

This is a semi-structured quantitative and qualitative research focused on interview techniques [8] with the theory of Social Representations [9,10] as a benchmark for analysis of speeches and participant observation [11] from the monitoring of ES practices, as RS are expressions related to language, ideology and social imaginary, guiding behaviors in the everyday of social groups, creating "consensual universes" [9].

Interviewers were twelve undergraduate students from different health areas, fellows of the PET-Saúde project, who initiated weekly activities in six ESF units under the supervision of the teacher.

Prior to data collection, students participated in three workshops for the development of the interviewing technique. In this process, while one student played the role of interviewer, the other played that of interviewed, both being assisted by other students. At the end of each activity, the strengths and weaknesses of the interview process were discussed.

Interviewers relied on a semi-structured interview guide, highlighting the purpose of the research for the guidance of questions. Students conducted the interview from three inducing themes: "health", "education" and "health education", presented in this order to respondents. Interviewers had the goal of deepening the themes to achieve the research objective, i.e., understanding the representations of subjects on ES.

Due to the qualitative approach of this study, the criteria for defining the subject was not probabilistic and required no sample calculation. The inclusion criterion was being user or professional of one of the six ESF units included in the study. The method of saturation of themes was used to terminate the inclusion of subjects.

Seventy-five subjects participated in this study and were distributed into four groups: a) higher-education professionals, five nurses, three doctors and one dentist; eight professionals with technical training in nursing and dental health; c) ten community health workers; d) forty-eight users of ESF units. Users were invited to join the education groups that took place in the units, after care or through home visits.

Interviews were audio-recorded and transcribed in full, being submitted to thematic analysis, which is a variation of content analysis, characterized as qualitative research methodology [12,13], in order to reveal the social representations (RS) derived from constituent elements of the speeches of subjects [14].

The steps of the content analysis for data categorization purposes include [13]:

1- Enumeration: count of expressions of interest to the theme, generating frequencies described in Tables I, II and III as a result of this research in its quantitative dimension.

2- Analysis of content for identification categories arising from collected data (words, phrases, expressions).

3- Interpretation of meaning in the light of theoretical reference.

Thus, after successive readings individually and in the research group, enabling the identification of words or most recurrent expressions, followed by their count (enumeration), categories such as meaning cores attributed to inducing expressions were identified. In this process, data from words, phrases and expressions are counted and categorized to be further interpreted [13].

Results

For illustration purposes, three tables will show the frequencies of speeches by analysis categories and groups of subjects, their position by theme in the set of subjects as well as the transcription of a few speeches.

Table 1. Illustration of speeches by groups on the theme "Education".

	Transmitted knowledge - formal	Social and family value	Public policy	Not defined
Higher education N=9	"transmission of knowledge" (NS4) "Learning to read and write" (NS6)	"that is what you bring from home models" (NS2) "Education is not just teaching ... it is in daily life" (NS7)	"Education is creating good citizens for society" (NS1)	
Frequency	30%	50%	17%	3%
Higher education N=8	"acquire knowledge ... history, geography, health ..." (TE8) "to have education is to be able to answer correctly" (TE3)	"are the result of the environment we live" (TE1) "We are educated more by the culture in which we live" (TE2)		
Frequency	54.5%	45.5%	0%	0%
ACS N=10	"School for me influences more in this education" (ACS4) "Properly speaking" (ACS6)	"Education is about ... respecting older elders" (ACS1) "Creation given by the family" (ACS7)		
Frequency	31%	61%	0%	8%
Users N=48	"we need education that comes from school to get a good job" (US1) "Education is studying" (US13)	"Education is what we have at home" (US1) "learning education in the daily life" (US4)		
Frequency	31%	67%	0%	7%
Total N=75	2º	1º	3º	4º

Table 2. Illustration of speeches by groups on the theme "Health".

	Expanded concept	Individual self care	Individual welfare	Public policy	Not defined
Higher Level N=9	"biopsychosocial welfare" (NS1) "Quality of life" (NS2) "Access to consumer goods, cultural goods, medicines, dignified treatment" (NS6)	"healthy lifestyle" (NS5) "Self-care is to respect our body, proper nutrition, practice of exercises ..." (NS9)	"balance of factors that attack the and defend the body " (NS4) "Be good to yourself" (NS7)	"Concept that incorporated access to work, school, housing, food, etc." (NS8)	
Freq.	21%	17%	48%	14%	0%
Technical Level N=8	"to be well emotionally, have friends, have income" (TE1) "Physical, social and mental welfare" (TE5)	"wash hands before eating, after eating and brushing teeth" (TE3) "Good food, good habit" (TE8)	"be good physically, not having pain, eat properly, have leisure" (TE4) "Is to feel good about yourself" (TE6)		
Freq.	13%	57%	30%	0%	0%
ACS N=10	"is to work, to move, to continue life" (ACS3) "Quality of life, to feed properly" (ACS4)	"organization and cleanliness" (ACS6) "Maintain a healthy lifestyle, hiking" (ACS8)	"being good about yourself is one of the most important factors" (ACS9) "Be at peace with life" (ACS1)		
Freq.	28%	31.5%	37.5%	0%	3%
Users N=48	"having healthy food, housing, work" (US14)	"Go to the doctor more often, take treatment exactly as he says" (US1) "Taking medication, cleaning, bathing, keep hands washed" (US7)	"not only being well physically ... is also to be happy" (US8) "Is to live well, do what I like and what brings happiness" (US15)	"to have the right to health, everyone can take better care of health" (US20)	
Freq.	7%	48.5%	30.5%	9%	5%
Total N=75	3º	1º	2º	4º	5º

Table 3. Illustration of speeches by groups on the theme "Health Education".

	Transmission / Prescription	Social value	Self-care	Public policy	Not defined
Higher Level N=9	"to teach, to see if the person understood if she came back and did what we asked" (NS1) "Professional guidance for the user to take care of his health" NS4)	"transforms the person, the environment, ES transforms society" (NS2) "Which has a weight within society (ES)... that favors the union toward a common goal" (NS7)	"regular physical activity, healthy diet" (NS5)	"to exercise to build citizenship" (NS9)	
Freq.	40%	21%	16%	23%	0%
Technical Level N=8	"brushing in schools, following a strenuous monitoring" (TE1) "There should have be more lecturers ... because a lot of people goes in one ear and out the other" (TE3)	"social and family factors can greatly influence the ES" (TE8) "People who can control their health status learned from someone" TE7)	"talk about what they can do not to have diseases" (TE4) "People have diseases and need to be healed before working with prevention"	"show that health is a citizen's right" (TE3) "Health without education is incomplete" (TE7)	

			(TE6)		
Freq. ACS N=10	53% "many do not follow what we always try to teach"(ACS8) "The way to work this awareness" (ACS5)	12% "it is their very culture" (ACS9) "It's important to consider the collective not only the individual" (ACS6)	15% "it is important because they control their blood pressure" (ACS1)	20%	0%
Freq. Users N=48	50% "they help me with remedies" (US41) "We must listen and keep it, because it's no use to listen to all" (US38) "They teach me what I do to get better and have a better health" (US22)	12% "I participate in the group at my church and it is helping me a lot" (US36) "The human part should be worked early on with the family and the community" (US33)	18% "maintain good eating habits" (US32) "Willingness to learn, to persevere ... we participate in walking and water aerobic activities" (US29)	0%	0%
Freq. Total N=75	49% 1º	14% 3º	25% 2º	0% 4º	12% 5º

Discussion

From the participant observation technique, it was observed that health education practices carried out in most ESF units showed the following characteristics: a) objectives: almost always aimed to acquire healthy habits in the individual dimension; b) community participation: interest of users in joining groups was often small, except forn one unit. Generally, participation was limited to markedly passive audience with little direct involvement initiatives in the planning and execution of activities; c) methodologies and approaches: thematic groups focused on diseases or specific health conditions that inspire greater care were formed; d) motivation: there were difficulties in most units for the adhesion of subjects to educational activities, especially in groups with little continuity; e) compulsory character: in certain situations, to participate in education groups was a necessary condition for consultation, being a requirement for participation.

In this approach, researchers are focused on health education processes rather than on the subject.

The characteristics observed above, by the participant observation technique, identify themselves with the "traditional" education, considered hegemonic in the health care context [15].

Of the six ESF units, two developed group activities not focused on diseases, where participants could propose the themes and participate in activities like dancing, hiking or innovative methodologies, giving greater autonomy to subjects.

Data obtained from interviews presented in Tables I, II and III will be discussed from the respective inducing themes.

On the representation of the theme "Education", three categories were created, prevailing in groups as "social and family value", except among health professionals, whose most recurrent speeches are identified with the category "knowledge-transmitted-formal". It is noteworthy that the only group that has identified education as a "public policy" was the group composed of higher-education

professionals. The concepts identified by the different groups are based on the representative values of their experience, searching for a meaning. In this case, the popular segments revealed the appreciation of the family environment as an important symbolic element of the concept of education, also present in the other groups.

On the theme "Health", as shown in Table II, four categories in the speeches of subjects were identified, which when analyzed together revealed great association with the core concept of "individual self-care" and "individual welfare", followed by "expanded concept of health" and "public policy".

In the present study, the expanded concept of health corresponds to the health definition of Law No. 8.080/1990, which is the right to: "food, housing, sanitation, environment, work, income, education, transport, leisure, which "express the social and economic organization of the country" [16].

It is noteworthy that Brazil has undergone a health reform heavily dependent on a society reform, determining changes in the political, juridical and legal aspects that guarantee the full and universal right to health for citizens [17]. However, within society, structural reforms did not follow constitutional advances. The experienced need, especially of popular segments, may explain the gap of abstract concepts such as citizenship due to the urgency for assistance and care, explaining the differences among groups.

Considering the theme "Health Education", despite the challenge of the combination of two complex concepts, four categories were revealed, and the most active in all subjects "Transmission / prescription" and "Self-care" followed as "social value" and to a lesser extent, only among health professionals "public policy". This result shows some similarity with the concept of health, either by proximity or even due to the lack of clarity on the theme.

Study based on RS on "Health education" carried out with university students revealed four categories: "health as absence of disease," emphasis on "body health" health as "mind-body balance" and "ecocentric conception of health" [18].

Another study on health promotion conception carried out with ESF teams showed similar results. The main focus was the prevention of diseases in individual counseling activities, in groups or lectures. The prescription of individual behavior and lifestyle habits prevailed [19].

This way of conceiving "health education" as knowledge to be transmitted, prescribed and limited to body care is identified with the concept of "banking" education, which has the following characteristics: knowledge transfer and strengthening the contradiction between educator and learner, uncritical and oppressor process. This conception represents a paradox to the assumptions of the National Policy for Popular Health Education [1].

The training from new educational methodologies was a demand suggested by some professionals. This may indicate changes in the ES scenario towards a liberating education. However, the technique alone cannot be dissociated from the intentionality of subjects and can be used both to empower and to dominate in the health context.

The scenario of units under study is promising to deepen the debate on the concepts and practices of ES.

Thus, as suggested in a study on ES in the ESF, if on the one hand, the specificity of health contents distance health professionals from laymen, a processes marked by the domain of scientific discourse on popular knowledge, on the other, the social distinction historically built on the health professions preserves that distance. In this process, in ES practices, popular knowledge can be overcome so that technical and scientific knowledge will prevail, and little is questioned about its effectiveness and intentionality [20].

It can be interpreted from the speeches of subjects the reproduction of domination of the social context and dominant meanings of health such as the reproduction of the domination of some sectors over others, the de-politicization of health issues in the context of care and the reproduction of some meanings of rulers by the ruled, with prevalent exclusion of social health determinants.

As shown in studies [21,22,23], the integrity and autonomy of users are important principles for the ES and the care at SUS and EPS has great potential to reorient reflections and practices. However, its influence can still be considered diffuse and even against hegemony of services, although EPS is characterized as a social movement that gave rise to a historical process that influenced health policies and academia in Brazil [24].

On a deeper political connotation, Stoltz (25) describes the scenarios of health services as part of the social context, reproducing class conflicts and proposes the waiver of these professionals and users to attempts to technical and scientific update of the forms of care and disease prevention, approaches observed in this study, for involvement in the political struggle for social right to health.

This study presents the limitations of an exploratory study and its considerations should serve to expand the debate on training and health education practices in the context of care and empowerment of users of health services.

Conclusion

In this study, the speech used by professionals is frequently repeated in the representations of users, and the traditional orientation of health education is nuclear, with emphasis on disease prevention on an individual perspective, featuring a traditional education.

The education process is primarily revealed as transmission of technical knowledge and the prescription of habits for individual self-care, determining the health education practices in the FHS units studied.

In this scenario, the assumptions of PNEPS and the EPS principles are presented as empowerment possibilities for subjects, whether professionals or users in the position of teachers or learners, roles that can switch from the redefinition of the conceptions and practices of health education.

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