

Health Education in Family Health Strategy Under User's Perspective

ORIGINAL

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Abstract

This study aimed to know the perception of a user group on the subject. It is an exploratory, descriptive study with a qualitative approach. It was held in a Family Health Unit in the municipality of Campina Grande/PB. It was used a semi-structured interview script. For the analysis, the technique of collective subject discourse was used. The interviews were divided into three categories: Users' knowledge on health education; perception of users about health education activities; and the importance of health education. The speeches associated health education to a biological perspective, characteristic of medical care model and focused on the transmission of knowledge, where the disease is the professional's care object, opposing the perspective of health surveillance model.

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Keywords

Health Education; Primary Health Care; Health Promotion.

Introduction

As a priority for users of the Unified Health System (SUS), the Primary Care develops a comprehensive care that impacts the health status and autonomy of people and interferes directly on the determinants and health conditions of the community, considering the subject in his uniqueness and his socio-cultural insertion [1].

The Family Health Strategy (FHS) appears to reorient the care model due to its progress and its expansion and consequently to improve health indicators of the population [2]. Among the FHS objectives, there are the social production of health, held by the constant search for

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communication, exchange of experiences and knowledge among team members, and those with the community through health education actions set as a practice scheduled and assigned to all the professionals who make up the health team [1].

According to Souza (2007), the discussion on education and health in the FHS context is a challenge, not only in the health units but the management of health services in their various possibilities of intervention. Often, in practice, health education consists of some activity in the groups of SUS users that are linked to some program such as hypertensive, diabetics, pregnant women, and other primary care groups [3].

Professionals working in the FHS faced barriers when developing health education, both in the individual and the collective context. These main barriers are the resistance to change and acceptance of the new care model; the low level of understanding of users; and overwork of professionals [4].

In the context of the implementation of health policies in Brazil, Health Education is one of the main elements to achieve the results of the education process. Educational practices should focus on initiatives that promote the formation of critical awareness of the subject about his health, and not only change or giving information, which little contribute to improving the lives of the population.

Community participation in decision-making favor the development of awareness and reflection on the individual and collective subject placed in the context of SUS [5-6].

Regarding the challenges mentioned, when developing health education actions in the FHS, as well as the importance of health education practices for improving people's health quality, it is observed that not always the practice of health education has been developed by professionals [7]. Often, when there are practices, they are not in line for health education purposes in the FHS. In addition to these aspects, it is clear that the population does not recognize the health education as important for improvement of life.

Thus, the following question arose: How do ascribed users in a Family Health Unit perceive health education? This study aims to know the perception of a user group on the topic.

Method

This is an exploratory, descriptive study with a qualitative approach. The study was performed in a Family Health Unit (FHU) located in the Malvinas neighborhood, in the city of Campina Grande - PB, located in the mesoregion of Paraiba Agreste, 130 km away from the capital João Pessoa.

The selected FHS is characterized by an enlarged team, and it has a nurse, a medical, a dentist, a nursing technician, a dental hygiene technician and six community health agents. It also has professional of the Health Support Center (HSC): a Physical Educator, a Speech Therapist, a Nutritionist, a Social worker and a Psychologist.

The research was approved by the Ethics in Research Committee of the University Hospital Alcides Carneiro - HUAC/Federal University of Campina Grande - UFCG with the opinion number 20436013.2.0000.5182.

For selection, the following inclusion criteria were considered: registered users in the researched FHU; be over 18 years old; be a participant user of the education groups in the health of this health unit. The exclusion criteria were: users who were selected for the interview and did not accept to participate in the study. The research was conducted with 20 users ascribed to FHU, randomly selected during the data collection period.

Data collection was carried out in January 2014. A semi-structured interview script with two parts was used: the first one included the characterization of the subject data, the second was made up of three guiding questions relevant to the objective. The interview was conducted using a recorder as an auxiliary resource. The study participants were coded with the letter E (interviewed), followed in numerical order they

appear in the transcript of the interviews to preserve their anonymity.

Users awaiting attendance at the FHU in the days and shifts established by the researcher and the health team were interviewed. A private room in the establishment of health was used to ensure their privacy and better accommodate them. The interviews were recorded and transcribed, and the use of data was by consent of the participants. The duration of each interview was 15 to 20 minutes.

Qualitative data were transcribed in full and organized in tables, built upon the testimonies and their selected categories. For the analysis, the technique of the Collective Subject Discourse (CSD) was used⁸. This technique consists of a set of discursive data tabulation procedures arising from the testimonies of the participants.

Results and Discussion

Characterization of the Subjects

There were 20 users registered at FHU participating in the study, 16 (80%) were female, and 04 (20%) were male. Most of them, 08 (40%) were 26 to 33 years old, 05 (25%) were 18 to 25 years old, 04 (20%) were 50 or more and 03 (15%) people were 34 to 49 years old. As for education level, 10 (50%) of respondents had completed high school, 03 (15%) incomplete high school, 06 (30%) completed elementary school, 01 (5%) completed elementary school. Regarding occupation, 11 (55%) were unemployed, 03 (15%) were manicures, 02 (10%) were securities, 01 (5%) retired, 01 was cashier (5%), 01 dressmaker (5%), and 01 was general assistant (5%). Regarding the income, 12 (60%) had an income of 1 to 2 minimum wages (M.W.), 05 (25%) had 3 to 4 M.W., and 03 (15%) less than M.W.

The interviews were divided into three categories through the Collective Subject Discourse: users' knowledge of health education; perception of users

about health education activities; and the importance of health education.

Knowledge About Health Education

This category sought to answer the question: What do you understand by Health Education? It was divided into three central ideas: I do not know to inform (**Table 1**); Having a healthy lifestyle and care to not get ill (**Table 2**); and Receive information on how to take care of health (**Table 3**).

The interviews show the ignorance about the health education by the respondents. This fact is a negative factor since the FHU is considered the preferred way for users in the SUS; it is organized based on the attributes of primary health care that are geared to health promotion and prevention diseases.

In this sense, it is expected that the population knows about the health-disease process and the health determinants and conditions. Thus, they can establish relationships of these aspects to the importance of learning, considering education as a basis for construction of health knowledge. According to Almeida et al. (2014), it is necessary the subject know himself and his role on self-care [9].

Another aspect shown in **Table 1**, is that some statements indicated the hegemony of privatizing

Table 1. Collective Subject Discourse description about the central idea 1, answering the question: What do you understand by Health Education? Campina Grande, 2014.

Central Idea 1	Collective Subject Discourse
I do not know to inform	I do not know what it is... a long time ago I studied that I do not know if I am going to speak... frankly it does not come anything to my head; Let me see... when we get ill, and the doctor gives the medicine; I do not know what is.... I do not understand; I do not know if it from the doctor or us; Education is one thing, and health is another. Collective Subject Discourse of Respondents: (E3), (E6), (E11), (E14); (E18);

healthcare medical model when the doctor's work overlaps with the work of other health team professionals. The population still associates the work of the team as being directed only to medical practice. Users little value the production of care. Education is a strategy to the individual knowthe health-disease process and impact positively on the life habits and health behavior.

The health professionals training should be guided in the full model of dialogue and socialization of knowledge established by SUS, valuingthe health promotion and disease prevention, rather than a positivist, mechanistic model, centered on the disease and not on the subject [7, 10-11]. The discussion and reflection on this new paradigm have repercussions in an appropriate change in practice to meet the real health needs, with a focus on integrity and equity concept [10], looking for an improvement of the holistic view [7, 12] and recognition of the population.

Thus, it was shown that the user knows the service, but he does not know its real purpose. It is noteworthy that the knowledge among the population about the FHU objectives favors its understanding regarding the importance of developing health education actions to improve the health status of the population, but also awakens the community interested in enhancing teamwork in disseminating health education information to promote better quality of life for people who workin the team.

In **Table 2**, it is observed that the testimonies of the respondents are related more to the knowledge of "being healthy" than the very meaning of "health education."

It is noticed that users refer to health education as actions and attitudes that benefit their health. Health education can be understood as a dynamic action, which seeks the critical reflection on the determinants and conditions of the health-disease, which makes the individual an active agent and transforming hisreality. This strategy recognizes

Table 2. CollectiveSubject Discourse description regarding central idea 2, answering to the question: What do you understand by Health Education? Campina Grande 2014.

Central Idea 2	Collective Subject Discourse
Having a healthy lifestyle and care not to get ill	It is well-being, be well assisted when arriving at the health center, having a good diet, practice exercise, take care of our health; I think it's the person to have a healthy life; To do everything to not have the disease; I think it is to have a good monitoring of the body and mind, to do everything right, all right, to be careful not to get sick, walking, be careful with what you eat; I just know that we need to take good care before the disease, we should not smoke, we do exercises; It is to take care, to educate to have good health, not to get sick. Collective Subject Discourse of Respondents: (E1); (E2), (E5), (E7), (E10), (E12); (E17); (E20)

common sense articulated with scientific knowledge [10, 13-14], establishing a horizontal relationship between knowledge, which promotes the exchange of experience between users and health professionals.

Dialogue is the central point for an effective and efficient health education, promoting the strengthening of links between users, users and health professionals, and those subject to health policy, aiming at the recognition of the community needs. According to Freire (2011), dialogue is the way humans interact with the world and people around him, who through contact with the other, there is achange in action and reflection, which leads to a different way of living. The dialogic action allows both the educator and the student contribute to the foundation of knowledge [15].

From the critical reflection, the educational practice allows the individual to know and recognize him as an agent of change, be a citizen. Therefore, there is an increased commitment to self-care, which provides increasingly healthy habits in his day-to-day and favors the continued promotion to

health [9, 16], and to prevent problems due to the integration of ideas and practices in daily life according to his needs [11]. The health professionals understand the importance of health education in life of others to observe changes of habits due to a greater understanding of the subject. [12]

The health worker is a facilitator of experiences [7, 12, 16], and need to understand the concept of health education, not limited to the vertical exchange of knowledge, but to the joint construction of knowledge, which fosters self-responsibility, co-responsibility and active participation of the population and the consequent development of autonomy and citizenship [12, 14, 17], besides awakening the professional to the new and the real meaning of educational practices, which includes the subject responsible for his health and prepared to change his reality.

The statements below indicate that for some respondents, health education takes place through the health information transfer, and it is related to the disease, its prevention, and care. **(Table 3)**

One of the main activities of the family health team is the development of the vocational education practices, and these practices should encourage individuals to have their capacity for autonomy and be co-responsible for their health, thus not merely based only on the transmission of knowledge.

The FHU discusses the concept of health education in a more expanded way, since the teams develop strategies of interaction between dialogues, knowledge and experiences, providing to build a space and strengthening health actions [13] and close the relationship between health professional and users to meet the improvement of the quality of life.

The educational actions are a time of reflection and debate that favors dialogue and the exchange of experiences and knowledge to understand the individual and collective needs of the population and add knowledge to the actors involved in the process [16-17]. It is necessary to adopt teaching

Table 3. Collective Subject Discourse description regarding the central idea 3, answering to the question: What do you understand by Health Education? Campina Grande 2014.

Central Idea 3	Collective Subject Discourse
To receive information on how to care their health	It is an orientation that we received to get better before, during or after the disease; It is a way to educate through health... lecturing; It is when the agent receives guidance of the doctor, nurse and health worker for health care; There are the lectures we have to find out information about our health... in the group of elderly, high blood pressure; It is when someone gives you some information in the health center, the television and even on the radio how to take better care to avoid getting sick. Collective Subject Discourse of Respondents: (E4), (E8), (E13); (E15); (E19)

and learning methods to encourage community participation. According to Brasil (2007), this tool should prompt the observation and analysis of reality, producing a critical and autonomous human being [5].

Figueiredo, Rodrigues-Neto, and Leite (2010) explain that the transmission of pedagogy used in educational actions can provide knowledge scientifically produced to the population, and it can extend existing information and knowledge. However, the application of this knowledge to their reality can be hampered by their passive state during the learning process [18].

Perception of Users about Health Education Actions

This category sought to answer the following question: How do you perceive the achievement of educational actions in this Family Health Unit? Its central idea was: sometimes they perform **(Table 4)**.

Through the speeches on the central idea in **Table 4**, it is possible a clear expression of the respondents about the need to carry out health education practices by the family health team. The speeches show that there is a distance from the real role of

Table 4. Description of the Collective Subject Speech answering the question: How do you perceive the achievement of educational actions in this Family Health Unit? Campina Grande 2014.

Central Idea 1	Collective Subject Speech
Sometimes they perform	Here sometimes there is a lecture, but almost no one comes...I think they should do more lectures; they should do lectures for the community so they could ask more about diseases that not all of us know; there are many things that we do not know and it should be explained to the elderly, hypertensive; To me here it has little, but it is so important; Here it is, but it's just, it is to treat, and that is it; There are some diseases that they say here in the group talks, other not, they should have. Collective Subject Discourse of Respondents: (E1); (E8), (E12), (E15); (E17); (E19)

the health team with responsibility for the health of the population, and they do not actively participate in the activities developed by the unit staff.

Another aspect shown in the discourses emphasize that the population has a health education view focused on the biological view, focused on the disease, a predominantly curative approach that does not value community participation and not considering the health needs of the population. For Gazzinelli et al. (2005), this type of education follows a traditional model of the imposition of knowledge to the patient. When the linear relationship between the established knowledge and the behavior happens, education becomes normative [19].

It is also noticed that the respondents are aware of their real needs, and they can give suggestions. However, some health education practices considered traditionalists from the teaching-learning process are still remembered by the respondents, for example, the lectures by the professionals. Many of them believe that the "lecture" is still the method that best symbolizes health education [20].

For Chiesa and Verissimo (2001) in the said educational activities such as lectures, whether in groups or individual consultations, there is the idea that the disease is mainly due to lack of care and population neglect with their health, where the "victim" feels "guilty" for his problem [21]. As a result of this practice and among other problems, the low bond of the population to health services, poor adherence to programs and treatment and frustration of the health professionals were identified.

Following this results, Besenet al (2007) highlight the importance of the health sector to support an education not only in giving knowledge historically accumulated but that mainly work in the construction of knowledge and quality of life for all those who participate [22]. In this sense, Alves (2005) adds that education for health is to go beyond curative care, giving priority to preventive and promotional actions, recognizing the health services users as subjects with knowledge and living conditions, encouraging them to fight for more for their quality of life and dignity [23].

Providing quality care implies knowledge and good relationship between staff and family, considering their doubts, opinions and acting on the proposal of their actions. Therefore, it is important to consider the effect of culture on the health of each family, respecting their beliefs and health practices, values and family roles, communication patterns and family coping [24].

Health Education Importance

This category sought to answer the question: Describe the importance of developing health education actions by professionals in this unit. The central idea was: Health education is important (Table 5). It is observed that the respondents confuse "health education" actions with "have good care by professionals."

It is noted that the respondents know the importance of health education actions and the access to these actions provides greater knowledge and

Table 5. Description of the Collective Subject Discourse answering the question: Describe the importance of developing health education actions by professionals in this unit. Campina Grande, 2014.

Central Idea Central	Collective Subject Discourse
Health education is important	I think it's important because there are a lot we do not know and if they speak we already know and avoid many diseases; It is too important to make everyone learn and learn in a way... to make everyone just right and not get sick; I have learned very important things here you never even knew existed; It is important, it is necessary... there should be more information and talks to prevent various diseases. Collective Subject Discourse of Respondents: (E2); (E6), (E9); (E16); (E17);

learning about their health. The interrelationship between the actors gathers beliefs, values, experiences, signs and meanings about the health-disease according to each to form the group characteristics [9].

One observed aspect in **Table 5** was that despite the respondents considering important the development of health education actions, several testimonies aimed at the "disease." In this regard, Besenet al (2007) state that the professional-patient relationship appears horizontally without imposition or authoritarianism. However, he is not able to undress the rigor of scientific knowledge regarding the prevention to biological, as absolute truth and only to be inserted in the knowledge of individuals [22].

The health education concept is anchored in the concept of health promotion, being the processes that include the participation of the entire population in their everyday life context and not just people at risk of becoming ill. This concept is based on a positive and dynamic welfare state search integrating the physical and mental (absence of disease), environmental, personal and social

aspects. The critical concept of education tends to aware for change, for freedom and ask for a close relationship between the professionals and the population [25].

Based on the principle of integrity and acting in health, services should offer health promotion, prevention of risk factors, care for injuries and rehabilitation according to the dynamics of the health-disease, and these should be coordinated and integrated into all organizational health system areas [26].

Conclusions

Despite the advances in SUS, such as primary care that must develop a work based on the promotion of health, there are still users who are unaware of the meaning of health education actions.

In this research, speeches linking health education to a biological perspective were perceived, characteristic of medical care model and focused on the transmission of knowledge, where the disease is a professional care object, thus opposing the perspective of the health surveillance model.

It is worth remember that statements also indicate that users relate health education to the prospect of the broad concept of health, where their real health needs establish a relationship with the conditions and determinants of health.

Health services need to program actions on the determinants of health-disease process, causing the population to be involved in the discussions related to health education and these actions guide the population to be a partner in the production of health.

In this sense, while being a member of the Family Health Team and health educators, it is essential that health professionals develop activities aimed at education and training of users with this team so that they can know and understand their health-disease process. Health education is the way to make citizens more responsible for their health and more involved in building a healthy society.

This study provided reflections on the role of professionals working on the Family Health Strategy about their performance in the development of health education actions with the population, also arousing interest for more studies to further investigate the issue.

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