HEALTH EDUCATION: THE FAMILY HEALTH TEAMS' PERSPECTIVE AND CLIENTS' PARTICIPATION[1]

Maria de Fátima Antero Sousa Machado[2]
Neiva Francenely Cunha Vieira[3]

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This study aimed to understand the conception and performance of health education developed by the Family Health Team with a view to clients' participation. Qualitative study carried out with clients and professionals at the Family Health Program (FHP) in Crato, CE, Brazil. Data were collected through semi-structured interviews and observation between May and September, 2005. Data were organized according to content analysis and literature. Findings indicate that professionals view health education as guidance and teaching focused on disease prevention and the participation of clients is perceived as listening and attention. Thus, FHP professionals need to broaden their understanding of health education and educative strategies, which should be culturally meaningful, so that clients freely and consciously decide on their participation and behavioral change in health.

DESCRIPTORS: health promotion; health education; consumer participation; family health program

EDUCACIÓN EN SALUD: PERSPECTIVA DEL EQUIPO DE SALUD DE LA FAMILIA Y LA PARTICIPACIÓN DEL USUARIO

Este estudio tuvo como objetivo comprender la concepción y la actuación en Educación en Salud por parte del Equipo de Salud de la Familia buscando la participación del usuario. Se trata de un estudio cualitativo con usuarios y profesionales del Programa Salud de la Familia (PSF), del Municipio de Crato, estado de Ceará, Brasil. Los datos fueron recolectados a través de una entrevista semiestructurada y de observación, entre mayo y septiembre de 2005; fueron organizados mediante análisis de contenido con base en la literatura. Evidenciamos que el proceso educativo es percibido por los profesionales como orientar y enseñar a prevenir enfermedades. La participación de los usuarios significó escuchar y prestar atención. Se concluye que los profesionales del PSF necesitan ampliar la comprensión de la educación en salud y de estrategias educativas culturalmente significativas para que la participación y decisión de cambios de comportamiento en salud de los usuarios sean libres y conscientes.

DESCRIPTORES: promoción de la salud; educación en salud; participación comunitaria; programa de salud familiar

EDUCAÇÃO EM SAÚDE: O OLHAR DA EQUIPE DE SAÚDE DA FAMÍLIA E A PARTICIPAÇÃO DO USUÁRIO

Este estudo objetivou compreender a concepção e a atuação de Educação em Saúde pela Equipe de Saúde da Família, objetivando a participação do usuário. Estudo qualitativo com usuários e profissionais do Programa Saúde da Família (PSF), do município do Crato, Ceará, Brasil. Os dados foram coletados através da entrevista semiestruturada e observação, entre maio e setembro de 2005, e organizados mediante análise de conteúdo e à luz da literatura. Evidenciou-se que a Educação em Saúde é percebida pelos profissionais como orientar e ensinar a prevenir doenças. A participação dos usuários significou escuta e atenção. Conclui-se que os profissionais do PSF necessitam ampliar a compreensão de educação em saúde e de estratégias educativas, culturalmente significativas, para que a participação e decisão de mudanças de comportamento em saúde dos usuários sejam livres e conscientes.

DESCRITORES: promoção da saúde; educação em saúde; participação comunitária; programa saúde da família

[1]Paper extracted from Doctoral Dissertation; [2]RN, Ph.D. in Nursing, Faculty Universidade Regional do Cariri and Universidade de Fortaleza, Brazil, e-mail: fatimaantero@uol.com.br; [3]RN, PhD., Adjunct Professor, Universidade Federal do Ceará, Brazil, e-mail: nvieira@ufc.br.

INTRODUCTION

Education in health and the participation of clients are essential elements for personal and structural changes to occur in health promotion. These statements are present in the Ottawa letter from the first international health conference in 1986. This international movement was followed by others, which have ratified the direction for greater interaction among professionals and clients, mainly valuing preventive actions and health care in a socio-sanitarian, inclusive, ecologic and joint dimension to improve quality of life[1].

Education in health, in an enlarged conception of health care, requires the participation of clients in the mobilization, training and development of individual and social abilities to deal with the health-disease process, and also needs to be extended to the implementation of healthy public policies.

Health professionals and clients are the social actors who are in continued interaction. Therefore, the therapeutic project should incorporate health care actions that transcend the limited clinical conception of curing diseases and value the context, the social determinants, the subjectivity of the health-disease process and also the inclusion of clients as active, autonomous and participative individuals. When the term therapeutic project is used as a route to the care plan, it is understood that health promotion is the main objective of health professionals' practice at all levels of care. This understanding requires a multidisciplinary and complex view of a variety of actions and shows that professionals should overcome the traditional and limited view of care focused on the disease. Similarly, patients in treatment should be encouraged to adopt temporary or permanent changes, consequence of disease and/or suffering processes[2].

Reaffirming health promotion as the ultimate goal of the therapeutic project implies the cultural transformation of health institutions like hospitals and basic health units, into healthy organizations that focus on the valorization of people who, in turn, should participate and decide on care plans at any level of health care[3].

People's power and control over their own destiny allow them to produce concrete and effective actions in the decision-making process to meet priorities, and to define strategies and their implementation to improve health conditions, so that individuals can cope with diverse phases of their existence and illnesses[4].

However, the power and control of clients can only be exerted through their full participation in Health Education. The Family Health Program (FHP) aims to promote health and the health team's role is to do its best so that behavioral changes in health occur in a continuous process of learning and participation of clients, in the way they act for themselves, for the family and the environment, making it possible to transform people into active and collective persons.

In general, the clientele's participation in educative actions is passive and encounters are conducted through the mere transmission of information from those who know (health professionals) to those who do not (clients)[5]. This attitude in the educative process impedes people from identifying their problems and critically reflecting on their causes so as to find strategies, overcome obstacles in the direction of health promotion through changes in their own lives[6].

These reflections led to the study objective, which is to understand the conception and development of Health Education by the Family Health Team (FHT), aiming for clients' participation.

MATERIAL AND METHOD

This qualitative-descriptive study was carried out in Basic Health Units that work with the Family Health Program in Crato, CE, Brazil. Currently, there are 24 FHTs, 14 in the urban area and 10 in the rural area. The research participants were five teams in the urban area which were hired by the FHP for more than five years, taking into account their experience with clients. Forty-two clients and 32 professionals from the FHP were included in the research, totaling 73 interviewed individuals.

Data collection was carried out through semi-structure interviews and observation guided by a checklist. The first instrument used consisted of an interview directed to clients and another one directed to professionals. Interviews addressed aspects related to the user's participation in the FHP and were recorded after the participants' authorization. When participants did not authorize cassette tape recording, data were manually recorded by the authors and then read by the interviewee to confirm information provided. Only one user refused this procedure, so

that his entire report was recorded in the field diary. All interviews, with both clients and professionals, were held at the basic health unit itself, with duration from 30 to 50 minutes.

The observed educative meetings were those planned and developed by the teams, with topics and strategies they had chosen. Similarly, talks, groups and waiting rooms were observed, with an average of two to three observations per FHT.

The organization of data and construction of categories were based on content analysis[7]. These categories formed the conceptual map of analysis of how Health Education is developed in the Family Health Program. Data analysis was based on reviewed literature, addressing Health Promotion, Health Education and Family Health Program and Participation.

The project was approved by the Research Ethics Committee at the Federal University of Ceará and complied with all formal requirements of Resolution 196/96 by the National Health Council and Ministry of Health, which rules research involving human beings[8] (process 86/05).

RESULTS

These study data are based on the relation of the Health Family Team in the Health Education work process. We opt to present what the team understands as health education, followed by the participation and manifestation of clients on their inclusion in educative actions.

The understanding of the FHT on Health Education

The interviewed professionals understand Health Education as the transmission of content, exchange of information, instruction, guidance of understanding, orientation, explanation, teaching and disease prevention. According to observations carried out with the FHTs and the participants' report, these actions are focused on disease prevention; the themes addressed by teams were defined by life cycle or pathologies, while only two of them were about prenatal care and one about oral health.

I view health education as instruction you pass through professionals (Physician 1).

I think that we are interacting, the professional and the client, we exchange information, then he comes and you can see if he is understanding that, 'cause we pass a lot of information, but don't know if the person is being educated in relation to health (Nurse 1).

We have to pass on what is the best for people, to know how to talk, we have to orient, say everything really well so they do their hygiene, and follow their treatment (nursing auxiliary 1).

Health education is to make them understand and prevent diseases (ACS 1.2).

It is a work mainly directed to needy communities, it is a work that you have to do in schools, in the community, in the family, so that their health is good (Nurse 4).

The perception of the FHT about Health Education is focused on disease prevention. The predominance of themes in the area of biological determinants of disease is observed in educative encounters.

FHT and its practice in other scenarios

The use of resources existent in the community for the development of educative actions is valued by the FHT. This attitude is in agreement with integral and intersectoral principles and, thus, strengthens the Single Health System. It is evident when the team reports the search for partnerships with schools and daycare units in the community as well as other institutions in the city for the development of educative activities with clients.

We have groups of hypertensive patients, pregnant women, we also have a school group; we're always working with the school and here at the daycare with a group of mothers (Nurse 1).

We also work at the school, whenever I ask for a room and request the students' presence to give a talk, they always provide one (ACS 3.1).

When we plan an activity we call people from the FNS (National Health Foundation) and they give talks, teach how to prepare multimix food (ACS 5.2).

Using the potential of communities is an important strategy in the educative process. The FHT should value groups already existent in the community, regardless of their nature. The authors had the opportunity to find a group organized for more than ten years in one of the assigned areas in the community. This group was composed of women and worked with music and regional dance. The authors observed the involvement of the group participants with all components of the team, including their participation in the educative program through the presentation of a song, composed by the group itself, which was focused on dengue.

Clients' participation

The family health team reported that the clients' participation in Health Education actions is incipient, supported by material coercion, and that there is no interest, though exchange of ideas and clarification of doubts have been observed. Some resources used by professionals to encourage participation of clients in Health Education actions are harmful. We have to keep in mind that bargain and coercion compromise participation. The use of this expedient reinforces patronage and dependency. When these tactics are not used, clients no longer participate. The decision to participate in an educative process should be conscious, free and spontaneous, an option to experience the educative action, not encouraged by any bargain mechanism.

I still think participation of clients in the health education process is very poor, also, their participation in the service is very poor (Physician 1).

They still participate very little, I gathered a group in women's health, gave talks and very few women came, comparing to the number we have in the area (Nurse 1).

They pay attention, they talk, exchange ideas, give examples also, it's cool (Nursing auxiliary 1)

They listen, ask very few questions to clarify doubts because they are shy or afraid (ACS 3.3).

The community, the majority, almost has no interest in this, it's so little interest that it's hard to gather people. We schedule it, get a video to show them something, two, three or four attend... they are not very interested in this, only in those actions they'll get some benefit (ACS 4.3).

In the beginning very few would come, but then we started to think and create strategies, for example, if we have ten pregnant women who don't want to attend the encounter, we get something to dispose off in a raffle, or get to each of them something for their baby's outfit, so we started to encourage them this way and they increased their attendance to encounters (ACS 5.3).

Responses of clients regarding Health Education actions

The participation of clients in actions developed by the FHT in Health Education should be highlighted. As stressed in their reports, these actions represent a place for listening, learning, and though it is still incipient, the process has already exerted a positive impact.

She was explaining about cleansing, the hygiene of children's teeth; because one-year old children already have to have their teeth cared for and so forth. I didn't ask anything because I wasn't prepared at the time (U-1.3).

We learn with them and then pass to our group of children and also pass it to our women because there are 17 women in our group (U-1.4).

I don't ask anything, I memorize what they say in my mind and use what is the best (U-1.6).

I like to participate by listening and, if I don't understand, I ask and show my interest (U-2.6).

These reports characterize the participation of clients in the educative process developed by the FHP, whether attending talks or meetings, learning to practice, reproducing information transmitted or asking.

According to clients, the participation in the educative process developed in the FHP is focused on normative practices.

The difficulties faced by the FHT in the development of Health Education

The difficulties mentioned by the professionals are related to management. There are barriers related to the organization of work processes because of the great demand of services, which define priority of attendance, and also due to the absence of technical resources to optimize communication between the FHT and clients, such as didactic material and audiovisual resources.

Resources are always difficult to arrange, like transport, didactic material, you know, these things needed to give talks (Physician 1).

We don't have DVD, don't have slides, but the team brings some chocolate, some sandwiches, condoms, is always trying to innovate, call and mobilize these adolescents so they participate, because adolescents are very hard to gather, if you don't do something very attractive, they go away (Nurse 4).

One difficulty is related to the great health demand here at the unit, there're few talks so far; I think there should be more, but we don't have much time for that (Nursing auxiliary 4).

DISCUSSION

Health education practiced in services is still focused on people affected with illness or those susceptible to have their health condition altered. Thus, professionals direct their work to individuals who seek health services because of some potential pathology[9], which is also evidenced in the study.

In this perspective, actions carried out by FHT in Health Education are focused on normative

processes and guided by the clients' demands. The normative educative process is vertical, that is, professionals define what to address, and how and when the process will happen[10].

Another finding evidenced in this study indicates that Health Education actions were restricted to sets, that is, practices were planned by the teams, with scheduled dates and times, which were carried out at the same unit or at another place in the assigned area. This conduct certainly limits the range of actions related to Health Education when these are ordered and normalized, without reflection on other spaces or educational aspects. The educative process is limited to educative encounters programmed without the perspective of continuity, carried out according to the FHP routine.

The silent coercion adopted by the FHT to stimulate the participation of clients in the educative process hurts the principles of freedom of choice and decision. Education is a collective and joint action, which cannot be imposed, that is, one learns when (s)he is at the same level, side by side, and educators cannot bring their knowledge and method ready to this world[11]. Thus, Health Education should contribute to individual and collective awareness regarding the population's responsibilities and rights, encouraging participation of the community[12]. In this sense, we highlight that educative strategies are extremely welcome in the communities where the FHT is active; both discovering and valuing their potential, and that of other partners in the city, exchanging experiences and knowledge[13].

The management of services for Health Education actions was appointed as a barrier for the development of this activity. However, the FHT complains regarding limitations imposed by the absence of audiovisual resources and didactic material. This should not inhibit this practice. We stress that educative processes occur with people, and they are more important than resources. Thus, we argue that the valorization of people in the process can overcome any difficulty found. The local culture, conversation groups, mobilization and dialog, and other resources and means existent in the assigned area, should be known by professionals, who should not restrict themselves to importing resources for use in the community. The FHT should get integrated with the local community's communication strategies.

The valorization of hard technological resources to the detriment of culture can be a bias of health professionals. It is important to observe the integration of humanistic and scientific culture, in which professionals need to value the individual, the context and culture in their daily lives[14]. In education, what is meaningful and symbolically visible to those involved, needs to be valued[15]. The technological equipment mentioned by the professionals may not be symbolically visible to clients. Perhaps what is symbolically sensitive to them is to know that, in the context of their lives, there are other people going through similar situations. Thus, in the discussion and contextualization of the fact, the group can grow and develop a learning process in health and citizenship.

There are divergences between professionals' and clients' reports with regard to the participation of clients in the Health Education actions in the Program. For example, clients did not report the exchange of ideas and experiences.

Participation is a procedural act of conquest of the subject in the collective construction[16]. We understand participation as a process that implies achievement, commitment, involvement and sharing, allowing individuals to form a critical conscience regarding the reality they are inserted in and, consequently, becoming autonomous and emancipated beings, able to make decisions that affect not only their life but also their family and community. This conception includes individuals who are citizens, idealized and expected to put the project of health promotion into practice.

The biologistic model focused on the disease still prevails in the country, whether incorporated in the professionals' practice or in the population's perception. The FHP proposed a different possibility for the organization of basic health services, as well as their relationship with the community. Professionals need to have a systemic and integral view of individuals and their families, work with their real needs and availability, with competent and humanized practice, and work for health promotion, protection and recovery[17].

CONSIDERATIONS

Health Education in the Family Health Program is perceived by the FHT as a strategy capable of transmitting content, information, instruction,

guidance and teachings, especially on disease prevention. The clients' participation in Health Education actions has been perceived, though it is still incipient.

A notable fact is that the FHT works with potential existent in the community, as well as other segments in society, to develop educative practices. Professionals acknowledge existing difficulties for the performance of these practices. In this perspective, we understand that FHT should dialog with clients and seek other forms of mobilizing them.

We also believe that Health Education in the Family Health Program represents a useful tool to change the clients' behavior in favor of health promotion. However, this study shows that policies for the implementation of health promotion are still ongoing. Health professionals who work in the scope of the FHP need to broaden their understanding of health education and the use of educative strategies that are culturally meaningful, so that clients freely and consciously decide on their participation and behavioral change in health.

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