

## REPRESENTATIONS OF HEALTH EDUCATION FOR A TEAM FAMILY HEALTH STRATEGY<sup>1</sup>

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### ABSTRACT

Due to the expansion of the concept of health emerged diversified proposals and alternatives in education, with discussions on approaches which achieve the desired levels of population health. Therefore, studying the Social Representations of professionals about the actions of health education offered by them to the community allows us to capture the meanings that these actors give to their practices; but, without underestimating the conditions under which they are developed. The purpose of this research is identifying the representations of the Family Health Strategy members about the health education. This is essentially a qualitative descriptive research, which was made in nine Health Centers with Family Health Strategy, in the city of Curitiba-Paraná, along with 58 health professionals. The data were collected in July to December 2010, through semi-structured interviews, after that the transcripts were submitted to thematic content analysis. It was founded two different modes of understanding of health education by professionals: "Knowledge Sculptors" and "Education for autonomy" and other conceptions, which prove the need for improvement and learning, and to invest in permanent education of professionals.

**Keywords:** Nursing. Health Education. Health Promotion.

### INTRODUCTION

With the expansion of the health concept of sickness absence for a balance between the social, economic, cultural, ethnic / racial, psychological and behavioral determinants, in which its conception is understood positively as a resource for everyday life, not as goal of living many proposals and alternatives to educate, which emerged from discussions about which approaches to achieve desired health population levels emerged<sup>(1)</sup>.

This concept inspired the implementation of the Unified Health System (SUS) in Brazil, which was stimulated by the Health Reform Movement, as the need to recast the model of

care. The ideals of this movement fostered a renewal of the right to health and the responsibility of the State, which has emerged as a new social pact in which health can now be defined as a "right of all". Thus, to ensure the SUS principles: comprehensiveness, universality, equity and participation of the population, the traditional models of seizure and responses to illness processes have become insufficient, since the conceptual bases of the reform of health care in Brazil brought as proposed implementation of the Family Health Strategy (FHS)<sup>(2)</sup>.

The FHS is a leading design of SUS, conditioned by the historical evolution that began in the beginning of the 1990s, aiming to reorganize primary care in Brazil. The

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operationalization of this strategy occurs through the implementation of multidisciplinary teams in health centers, which are responsible for the actions of health promotion, prevention, and recovery, rehabilitation of diseases and ailments and maintenance of community health<sup>(3)</sup>.

To address the fundamentals of FHS (humanized health practices, user satisfaction, narrowing of professional unknowledge, community respect and recognition of health as a right of citizenship and quality of life)<sup>(4)</sup>, health education is established as the main instrument, since this is an element capable of producing action and to act on the knowledge of people tending to facilitate voluntary actions conducive to health<sup>(5)</sup>.

Thus, the goal of health education is not to inform, but to transform knowledge, aiming to develop autonomy and individual responsibility in health care, by understanding their situation and not by the imposition of scientific knowledge. Thus, the individual is qualified to decide which strategy is best for your vision to promote, maintain and restore your health<sup>(6)</sup>.

In this perspective, studying Social Representations (SR) of professionals about the actions of health education afforded them by the community, allows us to capture the meanings that these actors give to their practices without, however slight the conditions under which they are developed. The RS can act as guides for interpretation and organization of reality, allowing the individual, in this context, the integral ESF worker, is in the world, and socially share these representations allows us to know how individuals understand the world in which they live and events the life<sup>(7)</sup>.

Given the important concepts addressed, the objective of this study is to identify the representation of members of the FHS about health education. Therefore this study is justified, because this knowledge will provide not only subsidies for continuing health education and for developing strategies that facilitate the interchange of health professionals in the community.

## METHODOLOGY

This is a qualitative descriptive study that used the social representations as a methodological support of analysis, considering these, a form of knowledge socially elaborated and shared aims and the interpretation of a common reality of a particular social group<sup>(8)</sup>.

The study was conducted from July to December 2010, nine Health Units with FHS in the municipality of Curitiba - Paraná, and 58 health workers. Subjects were coming from the draw of 20% of Health Units (USES) of the municipality, and the same percentage of components of the teams, which resulted in 10 USES, but there was refusal of a Sanitary Authority for the interview with the staff of your unit. Among the workers interviewed found: nurses, technicians and nursing assistants, assistants and technicians in oral health, surgeon dentists and physicians.

The data collection was performed on the premises of the HUs, through thematic recorded interview with open questions about what is health education. After transcription, the data were treated by the method of content analysis proposed by Bardin<sup>(9)</sup>, which proposes three phases: pre-analysis, material exploration and processing of results, inference and interpretation. This resulted in two categories: "Sculptors of knowledge" and "education for autonomy."

With regard to the ethical aspects of the research project was approved by the Ethics Committee of the Department of Health Sciences, Federal University of Paraná, under protocol number / registration CEP/SD: 890.015.10.02 (CAAE No 0010.0.091.000-10). In regard to anonymity, the workers were identified with the letter E followed by numerals in ascending order, as required by Resolution 196/96 of the National Board of Health, Ministry of Health (1996)<sup>(10)</sup>.

## RESULTS AND DISCUSSION

The average age of the 58 respondents was 43 years old, with a minimum of 23 and maximum of 61 years old, and only five were male. The service time at the institution in which he conducted the interview ranged from one month to 24 years. Of respondents had: three doctors, 18 nurses, 24 nursing assistants,

10 assistants and dental hygienists technicians and three dentists.

It is observed that the health teams are mixed, both in terms of number of professionals and working time in the institution.

In the first category, "Sculptors of knowledge", the subjects understand that health education is only a theoretical transmission of scientific knowledge, therefore the former are responsible for the modifications and adaptations of user behaviors in relation to their health, thus the worker is an artist who models the knowledge, as shown by the following statements:

You repress the guidelines about health in general [...]. It is working even the educational part that is important, it should be done, how people should act. (E 23)

For me health education is we educate the patient about the basics, so for him to have a health. Tell him to wash the food before eating, walking with wallet vaccine days. So are guidelines for preventing diseases and with that you will be promoting health. (E27)

[...] Teach him what the best ways of life, how to take care of his health, which is the correct power when he has a medication to use, how to use it properly, do not misuse this drug and have a life, so to speak, even to have a healthy life. (E30)

These ideas have historical roots, as several authors conceptualize education in traditional health as a leading model influenced by positivism, which centralized power in the health professionals, who were considered holders of scientific knowledge necessary for a healthy life. This concept is based in a biologicist referential, with the aim of changing individual behavior, from the models transferred to the maintenance of life<sup>(11-13)</sup>.

Thus, it can be seen in the statements of E23, E27 and E30 patronizing, in which users are considered in need of information about health and workers assume that from the knowledge imparted will assume these new habits and behaviors, so that users are considered objects of educational and responsible for changes in their lifestyle practices<sup>(6)</sup>.

The paternalistic attitude of health professionals is enhanced by exogenous model of disease in which there is an external causative

agent of the disease is that it should be eliminated, such as the cigarette that causes cancer, sugar diabetes, salt hypertension among others. Thus, these factors are considered direct agents and disregard other reasons those may be involved in the health-disease process<sup>(6)</sup>.

These attitudes of health workers disregard the life stories, the set of beliefs and values, the representation of the health-disease process and the user's own subjectivity<sup>(6)</sup>. Thus it is noted that some professionals consider themselves "superior" when reporting conduct health education activities as explained by the following statements:

It is a way to demonstrate everything that we experienced in the theory, combined with practice, and try to pass it in the best way for people in a way to be entering knowledge. [...] (E16)

Health education is that you are passing the knowledge that you know [...] somehow try to help them improve their health [...]. (E21)

It is the training of the multidisciplinary team and passing this training for users who need it actually [...]. (E31)

The professional is considered capable of "insert" knowledge, comparing the user to an "empty vessel" that needs content. It is noticed that in this traditional concept and vertical health education does not tend to the autonomy of subjects, often passive activities through the mass media, audiovisual resources, teaching classes and lecture in health centers, schools, churches and other centers community, and aimed to illness and curative intervention of the health-disease process. Thus, several critical to this concept are made of traditional education, since the determinants of psychosocial and cultural health behaviors are not weighted. Therefore, it is considered the individual as object and lacks information, excludes the idea that individual behaviors are guided by the values, beliefs and representations about the health<sup>(6,11)</sup> and education.

The training of health professionals is one of the core problems because they demonstrate not be prepared to work in the logic of Health Promotion requested by ESF. Most discourse is permeated by an education focused on the disease and to attempt to change the behavior of individuals, with vertical and imposing

relationship<sup>(14)</sup>. The work on the logic of health promotion, as recommended by the FHS aims to complete assistance to the user as a subject integrated into the family, the household and the community. For the scope of this paper, among other things, linking professionals and services to the community, and the prospect of achieving intersectoral action is required<sup>(4,15)</sup>.

Obtaining qualified professionals to work in this new model and rethinking educational practices within view of Health Promotion is not an easy task<sup>(16)</sup>. This difficulty occurs due to the formation of the professional model, still based on biologicist and fragmented vision. In a study conducted in Minas Gerais with coordinators, teachers, students and service professionals involved in nursing education was perceived in these speeches a decision for change in nursing education in which the concept of health promotion has been inserted. However, the authors point out that this change of the teaching-learning process, a biologicist thought for the incorporation of health promotion in nursing education is an uncertain and contradictory visions and practices for understanding the health of society transition<sup>(16)</sup>.

However, it is observed that some workers consider the reality of the proposal by the current healthcare system family, but excludes the exchange of knowledge and considers health education professional guidance only, without the active participation of the patient and family, staying with an idea traditional education as the lines of E28 and E40 below:

Health education is not only focused on one patient only, but on the whole family (...), we see the patient's problem, and through these complaints will accompany us in the house with the patient, family, and make the appropriate guidelines. (E28)

It's everything you do in relation to education, care, here we have the FHP which is a program that goes to the family to see reality, to guide the possibilities within the framework of the family [...]. (E40)

In the second category "Education for autonomy" Social representations of health education are linked to teamwork and the exchange of knowledge between the subjects of

educational action with the prospect of emancipation, according to the statements below:

[...] Is you make use of your knowledge, but also put people's knowledge, and you along with it seek to achieve some health promotion. (E1)

[...] They come to our employees, is demonopolarization of knowledge. It is not inherent in a person only, but for all users. (E20)

[...] Each educational activity we try to create in the patient the greater autonomy of it, is a greater concern for him and that they themselves also able to take care of his health with us, not only as a subject but also acting. (E24)

This view with the community participation in health education activities as speech E1 confirms the thought and theory of Paulo Freire in the 1970s, which called for liberating or emancipatory education as aims reflection and critical about aspects of individual and collective reality awareness and stimulating this search<sup>(17)</sup>.

However, to carry out health actions that provide autonomy as regards E24, it is necessary to know the individuals including their beliefs, habits and values, and the objective conditions in which they live, as well as engaging them, opposing the imposition held by education traditional. From this conception, the aim is the transformation of reality that is only "possible to ensure the sustainability and effectiveness of health"<sup>(6)</sup>.

The basis of this kind of liberating education is dialogue, in which the user is recognized for possessing knowledge, corroborating the speech E20. Thus, even if a different knowledge of the technical and scientific, this is not overlooked by health care providers, since they both act in different roles with equal heights, because only in this way it is possible to transform knowledge, aiming to develop the autonomy and responsibility of subject in health care<sup>(17)</sup>. The education that seeks the emancipation of individuals enables these to decide on the best ways to promote, maintain and restore their health through understanding of their situation and not by the imposition of a scientific knowledge. Dialogue by workers and users build a knowledge about the health- disease process in a shared manner by exchanging knowledge, enabling addition of confidence in health services, long-lasting changes in habits and

behaviors without persuasive or authority attitudes<sup>(6)</sup>. In a previous study, we highlight the work of nurses focused on educational practice as the main strategy for health promotion by acting in home visit because you can establish a consistent link between the patient / family binomial and health care services<sup>(18)</sup>.

The development of knowledge interaction allows for the construction of new meanings and individual and collective meanings of the health-disease-care process, with an expected change of behavior and resulting health actions through a complex process of subjective and objective factors in social, economic and cultural context as well as individual motivation. Thus, the role of health worker education facilitator is to provide findings and reflections for the (re) construction of reality in health disease process<sup>(6)</sup>. Therefore, professionals need facing chronic patients as partners in the production and care information, and not as mere recipients or receivers of the same<sup>(19)</sup>.

One realizes that educating goes far beyond what purely train another person in performing skills, and becomes the fundamental critical reflection to build or create possibilities for new knowledge, distinguishing the simple transfer. So, no need to change the paradigms of workers who view the individual as a receptacle of knowledge / content<sup>(20)</sup>.

## FINAL CONSIDERATIONS

Educate should not be an authoritarian dictator and passage way of knowledge, but should stimulate reflection on the experiences and the context in which the population is, finding a path of transformation of knowledge,

in addition to free and untie the dependency imposed by many professionals.

The "Sculptors knowledge" feeling holders of knowledge believe that shape population according to its teachings. However, health education, at present, focuses autonomy with self-care, self-government bodies and their self-health care, which contributes to the creation of new subjects.

Understanding health education as "education for autonomy" allows the exchange, growth and the possibility of building new knowledge with a critical consciousness that reflects and, allowing for the sharing of knowledge, to mediate meetings where the exchange of information prevails. However, that meets all demand levels, education must be planned for and with the people, where educators interact with students, realizing their needs, their level of interest, doubts, beliefs and culture.

Thus, stimulating the development of autonomy for health care becomes a shared process in which health professionals build together with patients with chronic diseases needed to maintain their quality of life concepts. So the goal is on the formation of reflective, critical and aware citizens, through a process of awareness, change and transformation.

The social representations of participants in this study were guided in two frames of education, traditional and liberating, and sometimes they are associated. However, it should be noted that the proposals by the Ministry of Health programs educational activities aimed at the autonomy of individuals, paradoxically, the formation of many of these professionals was conducted under the auspices of the biologicist model.

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## REPRESENTAÇÕES DE EDUCAÇÃO EM SAÚDE PARA A EQUIPE DA ESTRATÉGIA DE SAÚDE DA FAMÍLIA

### RESUMO

Devido à ampliação do conceito de saúde emergiram diversificadas propostas e alternativas de se educar, com discussões sobre quais abordagens atingem níveis desejados de saúde à população. Portanto estudar as Representações Sociais dos profissionais sobre as ações de educação em saúde por eles propiciadas à comunidade nos permite captar os sentidos que estes atores atribuem às suas práticas sem, contudo, menosprezar as condições nas quais são desenvolvidas. O objetivo do estudo foi identificar a representação dos integrantes da Estratégia de Saúde da Família acerca da educação em saúde. Trata-se de uma pesquisa de natureza qualitativa descritiva, realizada em nove Unidades de Saúde com Estratégia Saúde da Família, no município de Curitiba-Paraná, junto a 58 profissionais de saúde. Os dados foram coletados no período de julho a dezembro de 2010, através de entrevista semiestruturada, e após transcritos foram submetidos à análise de conteúdo temático. Foram encontrados dois diferentes modos de compreensão da educação em saúde por parte dos profissionais: "Escultores de conhecimento" e "Educação para a autonomia" e outros conceitos que

comprovam a necessidade de aprimoramento e aprendizado, devendo-se investir na educação permanente dos profissionais.

**Palavras-chave:** Enfermagem. Educação em Saúde. Promoção da Saúde.

## REPRESENTACIONES DE EDUCACIÓN PARA LA SALUD DE LA ESTRATEGIA DE SALUD FAMILIAR DE EQUIPO

### RESUMEN

Debido a la expansión del concepto de salud surgieron diversificadas propuestas y alternativas para educar, con discusiones sobre los enfoques que alcancen los niveles deseados de salud de la población. Por lo tanto, el estudio de las Representaciones Sociales de los profesionales acerca de las acciones de educación para la salud que ofrecen a la comunidad nos permite captar los significados que los actores dan a sus prácticas, pero sin menospreciar las condiciones en que se desarrollan. El objetivo de este estudio fue identificar las representaciones de los miembros de la Estrategia de Salud de la Familia en la educación en la salud. Se trata de un estudio cualitativo descriptivo, llevado a cabo en nueve Unidades de Salud con el Programa de Salud Familiar en el municipio de Curitiba, Paraná, con 58 profesionales de la salud. Los datos fueron recolectados entre julio y diciembre de 2010 hasta la entrevista semiestructurada, y después de la transcripción fueron sometidos al análisis de contenido temático. Se han identificado dos modos distintos de entender la educación sanitaria de los profesionales: "Escultores del conocimiento" y "Educación para la autonomía", y otros conceptos, lo que demuestran la necesidad de mejorar y aprender, para invertir en educación de los profesionales.

**Palabras clave:** Enfermería. Educación en la Salud. Promoción de la Salud.

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