



UNDERSTANDING OF POPULAR HEALTH EDUCATION BY A FAMILY HEALTH STRATEGY TEAM

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ABSTRACT

Introduction: Popular Health Education (PHE), based on Paulo Freire, seeks to recognize and confront health problems through dialogue with popular classes, respect for different cultures and recognition of the diversity of knowledge. **Objective:** to analyze the knowledge about PHE of nurses and community health agents (CHA) of the Family Health Strategy of a Primary Health Care Unit (PCU) in Fortaleza, Ceará. **Method:** Qualitative study conducted by semi-structured interview applied to four nurses and four CHA of PCUs in order to analyze participants' understanding about PHE. The findings were categorized according to Minayo's Thematic Analysis. **Results:** most professionals have worked between two and ten years in the service. Some of them know the basic concepts of PHE, but do not explicitly apply them on a daily basis. Most of them reported lack of time for consultations, maintenance and construction of groups and financial difficulty to purchase materials for PHE activities. Lack of humanization and biomedical and curative focus were cited. **Conclusion:** Most important actions of Popular Health Education are developed by the initiative of professionals, even without much basis and direction on the subject, given the lack of a specific protocol of workflow for conducting practices in the scope of PHE.

Keywords: Education. Health. Humanization of Assistance. Single Health System. Family Health Strategy.

INTRODUCTION

Popular Health Education (PHE) can be understood as a particular way of recognizing and facing health problems through dialogue with popular classes, respect for their cultures, recognition of their knowledge as valid and with the substrate of the theoretical framework of Popular Education developed by Paulo Freire in Brazil⁽¹⁾.

In this sense, PHE is inherent to all practices developed in the Unified Health System (Brazilian SUS) and represents an essential device both for the development of health policy in a shared manner, and for actions taking place in the relationships between services and with users. This has provided greater social inclusion not only by promoting the appropriation of the meaning of health as a right of the population, but also by promoting citizenship⁽²⁾.

According to the National Policy of Popular Education in Health (Portuguese acronym: NPPE-SUS), PHE constitutes a set of traditional

popular practices and knowledge that shows itself as a path to contribute with methodologies, technologies, and knowledge for the constitution of new meanings and practices within SUS^(3,4).

With the principle of joint construction, knowledge and dialogue between different knowledges, the PHE is configured as listening to the other and valuing their knowledge, praising the encounter with diversity⁽⁴⁾. It guides various health care practices and actions of social movements related to services. It seeks its expansion, improvement and daily construction in an integrated way to community dynamics by valuing knowledge and practices and prioritizing people in their territorial contexts⁽⁵⁾.

Popular Health Education should be thought from the perspective of social participation by understanding that true educational practices only take place among social subjects. Thus, it must be present in processes of continuing education for the social control of mobilization in defense of the Brazilian SUS and inserted in

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social movements that fight for a dignified life. The principle of integrity of the Brazilian SUS emphasizes the unrestricted approach to the integrity of knowledge, practices, experiences, and spaces of care at all levels of health care⁽²⁾.

Through the problematization of the situations experienced, Popular Education amplifies the actions of care, prevention and health promotion in health work, aiming at better life conditions and a more solidary and fair society⁽⁶⁾. Innovations are necessary to overcome technical asepsis and interact with popular dynamics, seeking individual and collective solutions to problems. The principle of PHE is the knowledge of experience based on knowledge produced in a shared way, in which people feel present, as defended by Paulo Freire⁽⁷⁾.

The development of health education actions in a dialogical, emancipatory, participative and creative perspective is necessary to contribute to the subject's autonomy in relation to his condition of subject of rights and author of his health and illness trajectory, in addition to professionals' autonomy before the possibility of reinventing more humanized, shared and integral ways of care. As a consequence, PHE stands out as a carrier of political coherence, social participation, and theoretical and methodological possibilities to transform old and traditional health education practices into pedagogical practices that lead to overcoming limiting situations of life and quality of life⁽²⁾.

Popular Health Education, as part of the daily practices of nurses and community health workers who routinely work with care, prevention and health promotion, can contribute to the improvement in the internalization of knowledge. This is because the methodologies used are active and dynamic, through groups, lectures in a horizontal way, experiences, conversation wheels and relaxing moments, fighting the banking model of education, just by sending knowledge. In this way, the educator would be a facilitator, as the educational process will be student-centered⁽⁸⁾.

We expect this study can sharpen the curiosity of nurses and community health agents (CHA) about PHE and, if appropriate, of other professionals in the field who work with the subject, through reflection in the study and

workprocess. It aims to change the performance of these professionals and lead them to reflect, directly and indirectly, about the stimulus to the empowerment of users and improvement in the quality of life of the population. Thus, the objective of this work was to analyze the knowledge about Popular Health Education of nurses and community health agents of the Family Health Strategy of a Primary Care Unit (PCU) in the city of Fortaleza, Ceará.

METHODOLOGY

The study was approved by the Research Ethics Committee of the School of Public Health of Ceará (CEP/ESP-CE, nº 3.318.496, CAAE: 11759519.6.0000.5037). All ethical and legal requirements for research involving human beings in Resolution nº 466/12, of December 12, 2012 of the National Health Council were followed⁽⁸⁾. This is a qualitative study based on the observation and interpretation of phenomena with the purpose of creating a hypothesis reaffirming the seriousness of the researcher's role⁽⁹⁾.

The study was conducted from May 1, 2019 to July 15, 2019 in a Primary Care Unit in the city of Fortaleza, capital of the state of Ceará, located in the Northeast Region of Brazil. The city has 312,353 Km² and an estimated population of 2,686,612 inhabitants⁽¹⁰⁾. The municipality has 115 basic health units (BHU) and 184 Family Health Teams that assist 66% of the population⁽¹⁰⁾. The PCU in question belongs to the Regional Health II of the city of Fortaleza, opening hours are from Monday to Friday, 7am- 7 pm, coverage of 60 thousand people in Mucuripe, Varjota, Vicente Pinzon and Meireles neighborhoods.

Currently, the Basic Health Unit has four Family Health Strategy teams. Each team has a doctor, a nurse and a nursing technician. The four teams together are composed of 19 CHA. The unit also has a coordinator and an assistant coordinator.

This health unit is in the field of action of the Multiprofessional Health Residence Program of the School of Public Health of the state of Ceará. This residence program offers the unit a multiprofessional team composed of dentist, physiotherapist, nurse, psychologist and social worker. The group acts in individual and

shared consultations and also in groups with health-focused activities. As part of technical requirements for the development of activities in the residence program, each group of residents is dedicated to only one team of the Family Health Strategy for a better performance of activities.

As this study was the final product of the Multiprofessional Health Residence Program of the School of Public Health of Ceará, we chose to work with the team assisted by the group of residents called 'Team 1', composed of a doctor, a nurse, a nurse technician and four CHAs. Furthermore, the unit is in conditions of great vulnerability, and nurses and CHAs are the professionals working more closely to the community, performing consultations, meetings, workshops and groups of health education, and to the territory.

Inclusion criteria were all nurses and CHAs included in 'Team 1' of the PCU, totaling eight interviewees. Workers absent from work activities during the days of interviews due to medical leave or vacation were excluded from the study.

After the presentation of the study, possible doubts were answered, and the Informed Consent form was delivered to participants, who responded a semi-structured interview. The choice for this methodology is justified by the need to understand individuals' subjectivity through testimonials in which subjects report their experience and analyze their history, extracting what is subjective and personal from the participant⁽¹¹⁾.

The interview consisted of a session with multiple choice questions about the socioeconomic situation and a second session with open questions following a semi-structured script to understand the knowledge of interviewees about Popular Health Education⁽¹²⁾. At the appropriate time for each participant, the space of a room in the unit was used. Participants were interviewed one by one and interviews were recorded for later transcription and analysis.

After the transcription of interviews, the Thematic Analysis of the empirical material according to Minayo⁽¹³⁾ was performed. In order to do so, an exhaustive and in-depth reading was performed to group the diverse perceptions into central themes containing diverse ideas in

the same thematic dimension. From this organization, the thematic categories were originated, which were derived from the nuclei of meanings present in the guiding questions, namely: What is the understanding of PHE? What is the importance of PHE? What changes came from conducting PHE? What are the difficulties in performing PHE actions? When appropriate, subjects' speeches will be presented with flower names to maintain the anonymity of study participants.

RESULTS AND DISCUSSION

No guest refused to participate in the study, and the average time for each interview was 45 minutes. Seven participants were female and one was male. One interviewee was up to 30 years old; six were aged between 31 and 50 years and one was between 61 and 70 years old. Most (5) professionals have been working between two and 10 years in the service. Two interviews have been in the PCU in question for more than twenty years, one has been in the unit for almost forty years, and three had no previous experience. These findings reveal an heterogeneous work team, composed of individuals who have been less time in the health service, and others who followed the process of building the Brazilian SUS⁽¹⁴⁾, creating the Community Health Agents Program and structuring the Family Health Program, nowadays called Family Health Strategy⁽¹⁵⁾.

When asked about schooling, two reported having studied until high school, two had a higher education degree and four had specialization. The unequal qualification of the team is followed by the disparity of salaries received by interviewees. Most (5) claimed receiving between one and three salaries, while three received between seven and eight salaries. These findings show that the value received by professionals is not followed proportionally by the qualification level.

When respondents were asked about their understanding of PHE, although they did not know how to define it, in general, they understood the importance and the respect for popular health practices. In addition, they raised the question about the lack of scientific evidence. None of them mentioned the National

Policy on Popular Health Education⁽³⁾, as seen below:

Popular health practices. There is no scientific evidence but the culture. (**Azalea, 52 years old, CHA**)

We must respect people's cultures, because in popular culture we learn many things, such as natural medication, massage therapy, popular beliefs, medicinal herbs. (**Anthurium, 44 years old, CHA**)

Family care. (**Begonia, 45 years old, CHA**)

You donate yourself, work with prevention, promotion and pass on information so that you don't get sick, work with the elderly, adolescents, people who use drugs. (**Calendula, 36 years old, CHA**)

It is based on the concern with promotion of health and recovery through dialogue and exchange of knowledge, valuing the knowledge that the population already has and from there, produce actions that will help to change their lifestyles. (**Cineraria, 42 years old, Nurse**)

Popular health education is a strategy that brings together community practices and knowledge for health care. (**Iris, 63, Nurse**)

The complementation of knowledge enables the integration of different types of knowledges in practice, establishing resolute and committed care to the reality of the population assisted, showing the true sense of integrality. Professionals and users present different health practices that need to expand for the occurrence of communication and generation of commitment to transform the knowledge of each one. As a consequence, knowledge and health are given in a process of dialogue, in which both commit themselves to transformation⁽¹⁶⁾.

The movement of PHE encourages the educational practice in a horizontal perspective of the worker-user relationship, providing interpersonal exchanges⁽¹⁶⁾. Through dialogue, the interest of the user population seeks to understand popular knowledge. This method recognizes users as subjects capable of providing a dialogical interlocution with health services and developing a critical analysis about the reality, thereby enabling the implementation of struggle and confrontation strategies⁽¹⁷⁾.

Thus, PHE should be recognized as the capacity of reorienting health practices by facing the cultural distance between services and the population cared for in a participatory and dialogical manner⁽⁵⁾. The importance of using PHE practices in daily activities was unanimously recognized by interviewees, especially for health improvement, as emphasized in the following reports:

Yes, it would encourage user growth and add new health information. (**Azalea, 52 years old, CHA**)

Yes, because we can work with art and field workshops, lectures, dynamics, and bring professionals who can help, also have music, painters, graffiti artists, you transmit your knowledge through popular education. (**Calendula, 36 years old, CHA**)

Yes, I use every day, whenever I can, I'm there, many times we cannot, I do it the best way possible, advising to seek medical help if one is not managing it alone, counting on friends. (**Camellia, 33 years old, Nurse**)

I think the use of popular health education in their territories by all health professionals is very important. (**Cineraria, 42 years old, Nurse**)

Yes, because care must be built collectively, combining clinical practice with popular knowledge and beliefs of individuals and the community. (**Iris, 63, Nurse**)

Some respondents emphasized that knowledge transmission is fundamental, with provision of guidance for help and direction. Others demonstrated knowing the concepts, although they did not make it clear whether they apply in daily activities. One of them clearly explained that he knows the concept and applies it in his daily activities. In only one of the interviews, was suggested the lack of effective knowledge about PHE and its daily application.

In Calendula's speech, she mentioned theater plays, the poem, the song, the clay doll, the lace, the dance, the intense painting, the massage, the circus acrobatics, the touching of care. Art represents the socialized dance. The artist makes the alchemy of cultures without making plans, calculations and knowing what will happen, but always including the community voice. There is a mysterious channel in which science and theoretical

reflection explain little, between the artists' work and the living dynamics of a culture composed of many wills, materials, desires, constructions, journeys and paths⁽³⁾.

Popular Health Education was very important for the creation of leaderships of the political movement, which encouraged the creation of the Brazilian SUS and the fight for its improvement. It guides health care practices and social movement actions related to services, aiming to expand and improve the construction of knowledge, practices and priorities of people in their territories, and rethink the training of health professionals⁽⁵⁾.

Health professionals' actions in relation to popular practices should be of respect, dialogue, love and solidarity, valuing the practices that defend the systematization of knowledge accumulated over several generations, aligned with clinical practice and work routine. Note the important role of several informal health agents who provide great popular support and possess knowledge based on a strong culture learned in daily social life. These actors may present great educational power⁽¹⁸⁾.

Health education is considered a fundamental strategy and not just an event that precedes the disease, and health professionals must be prepared for this action. This is accomplished when health promotion becomes understood as a way of thinking and doing health, where people are seen in their autonomy and political and cultural context as subjects capable of overcoming the instituted, through trust and questioning between the community and health workers⁽⁷⁾.

In this context, understanding how PHE practices can result in changes in the quality of life of the population is key for the identification of training gaps and improving the training of professionals who will propagate the practice. All interviewees recognized the importance of the practices to improve the life of populations, although those who reported practicing them, also value its application more, as shown below:

Yes, because either one or the other would put in the head what has to be done to improve health. **(Begonia, 45 years old, CHA)**

Yes, sometimes we manage to hold an event and change the way we think, we awaken desires and become friends, many times, they just need the listening and a differentiated look, awakening the desires. Many young people don't have the opportunity, thus offering options for them. **(Calendula, 36 years old, CHA)**

Yes, I believe when we do this, it gets better, I accompany the families, many times in the moment of pain I support the families, they feel embraced, I give them confidence. **(Camellia, 33 years old, Nurse)**

Yes, because the population would participate in the health-disease process from the traditions and cultural inheritance of their ancestors. **(Iris, 63, Nurse)**

It is important to rethink health education according to a perspective of social participation, understanding that true educational practices only have value among social subjects if we consider health education as a path to the constitution of active subjects moving towards a liberating life⁽⁵⁾.

It is essential to train human resources under the PHE logic through permanent education with educational strategies for the internalization of PHE in training courses for health professionals, as well as in postgraduate and continuing education courses, culminating in a possible improvement of professional performance in the territories⁽⁴⁾.

For the implementation of any practice, planning and a physical and organizational structure compatible with what is intended to be offered are necessary, as well as management commitment to the implementation of new actions⁽¹⁹⁾. Thus, when asked about the main difficulties faced in implementing PHE in daily practices, many reported the lack of time in consultations, for the creation and maintenance of groups, and lack of resources for the development of PHE activities. These problems hinder the application of PHE in the daily practices of health workers, as shown in the statements:

There are no defined protocols. **(Azalea, 52 years old, CHA)**

Due to issues of modern medicine, sophisticated equipment. **(Anthurium, 44 years old, CHA)**

Time, patients bring many problems in appointments. **(Begonia, 45 years old, CHA)**

Sometimes it's hard because we have to count on our own support, because people won't want to go just to look, if it's with children, they have to buy the material for the activities, spend and ask for help from the community. (Calendula, **36 years old, CHA**)

Lack of humanity, than a no in a more affectionate way, they leave more satisfied, they think because they are in the position of a doctor or a nurse, they can say everything, we have basic structures, but the activities do not happen. (**Camellia, 33, Nurse**)

Time availability to deepen in groups, activities outside those scheduled in the unit. (China Pink, **26 years old, Nurse**)

There are several difficulties, among them the lack of knowledge of many professionals about the subject, which leads them not to believe in the importance of PHE. (**Cineraria, 42 years old, Nurse**)

I believe the lack of information about the policy and the focus on the biomedical and curative model. (**Iris, 63, Nurse**)

In one of the speeches, the need for a workflow protocol to be followed was observed. However, there is no standard workflow. What we have is the Ministry of Health's booklet of Popular Health Education (*Caderno de Educação Popular em Saúde*), which describes the daily practices of this policy⁽³⁾. However, in order to be understood and put into practice, health professionals must have time to focus on reading and studying before its application.

The report of an interviewee about the lack of humanity in the service drew attention. The National Humanization Policy (NHP) of the Ministry of Health (2013) stimulates communication among managers, workers and users and represents the inclusion of differences in management and care processes. This policy seeks to build collective processes of confrontation, power relations, work and affection that often reproduce dehumanizing attitudes and practices, which end up inhibiting autonomy and co-responsibility of health professionals in their work, and of users in their care. The changes are built not by an isolated person or group, but in a collective and shared way, including and stimulating the production of new ways of caring and organizing the work.

This humanization provides community empowerment and the search for better living conditions⁽²⁰⁾.

In one of the reports, the focus on the biomedical and curative model, which understands health as absence of disease, was mentioned. The evolution of public health policies, as well as reflections about the academic training of professionals inserted in the Brazilian SUS raise several challenges. The curative, disease-centered health care model, in which the individual is seen as an object lacking autonomy, as his/her family/social context is ignored and abandoned, has influenced and determined some milestones in the history of these policies that, to a certain extent, are still found in daily health practices, because these are harmful to the integral health of families^(1,21).

In the process of learning the practices, the protagonists of PHE actions should seek a deep reflection and critical evaluation about limitations in their practices and know what paths can be built to overcome them. This should be thought with the objective of qualification and construction of alternatives for the main challenges in the Brazilian SUS⁽²²⁾.

Studies show that in the daily work of CHAs, PHE actions are reconsidered as the realization of lectures, delivery of pamphlets, home visits, appointment and guidance^(13,19). Among these activities, guidance provided to people is the action that actually comes closer to popular education, although it does not guarantee a dialogical approach, following the concepts of popular education to the detriment of an imposing and preventive approach^(2,3), because the lack of training and qualification in the area damages the practices. Thus, a training course in popular education is fundamental, so these professionals can have more clarity both about the importance of their work and the development of their educational practices^(13,19).

Although the discourse of educational practices in primary health care is valued by national management bodies, no specific proposals were provided for the development of these actions. In municipalities, reports of experiences using the reference of popular education in health practices have been common. In the professional routine of the Family Health Strategy, the follow-up of health

workers comprises technical actions oriented to health guidance, involving a network of affections and proximity built through the bond established over time, and may culminate in the empowerment of subjects and introduction in the reality of the Brazilian SUS^(23,24).

Over time, members of the Family Health Strategy have had their actions expanded, moving from the maternal-infantile focus to encompass the family and community. This was done by incorporating new knowledge and practices, highlighting the political and social fields. Especially CHAs, since they historically constitute a link between the health service and the community. Popular Health Education practices are developed at the initiative of professionals themselves, and managers often disagree with these activities⁽¹⁾.

Historical processes show resistance to popular participation, despite the growing awareness of the rights of the population. Patriarchalism, the slave regime and patrimonialism still influence the processes of popular participation and democracy. This discussion about the political character of social participation is still little discussed in the Family Health Strategy⁽⁵⁾.

Thus, the viability of these educational actions, not even popular education discourses in an instrumental way, restricted to the dialogue with users, seem to be enough to face the set of health care challenges in Brazil. Popular Health Education goes through the

democratization of relationships and redistribution of power⁽²⁵⁾ and requires the construction of new relationships among workers with their work and new forms of management and participation in health services⁽⁵⁾.

A limitation of this study was the fact of addressing two classes of health professionals, nurses and community health agents. This may have excluded the exposure of perspectives of other professionals in the area, based on other nuclei of knowledge, other experiences and daily work practices. This would open other possibilities of listening that could foster the construction of understanding and performance of popular health education practices within the Brazilian SUS. In addition, the difficulty with scheduling the room where interviews were performed, and the scarcity of free spaces in the routine of professionals made the process more expensive.

CONCLUSION

Clearly, for the most part, the important actions of Popular Health Education are developed by the initiative of professionals. Even without much basis and direction on the actions, with lack of a specific protocol of workflow for the conduction of practices within PHE, in addition to the insufficient support of the local and municipal management.

COMPREENSÃO DA EDUCAÇÃO POPULAR EM SAÚDE POR UMA EQUIPE DA ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO

Introdução: A Educação Popular em Saúde (EPS), baseada em Paulo Freire, busca reconhecer e enfrentar os problemas de saúde, pelo diálogo com classes populares, respeito às diferentes culturas e reconhecimento à diversidade dos saberes. **Objetivo:** Analisar o conhecimento sobre EPS de enfermeiros e agentes comunitários de saúde (ACS) da Estratégia Saúde da Família de uma Unidade de Atenção Primária à Saúde (UAPS) em Fortaleza, Ceará. **Método:** Estudo qualitativo conduzido por entrevista semiestruturada aplicada a quatro enfermeiras e quatro ACS da UAPS, com o fito de analisar a compreensão dos participantes sobre EPS. Os achados foram categorizados de acordo com a Análise Temática de Minayo. **Resultados:** A maioria dos profissionais trabalha entre doze a dezesseis anos no serviço. Parte conhece os conceitos básicos da EPS, mas não explicita aplicá-los cotidianamente. A maioria relatou falta de tempo nas consultas, manutenção e construção dos grupos e dificuldade financeira para compra de materiais para atividades de EPS. Citaram-se falta de humanização e foco biomédico-curativista. **Conclusão:** Majoritariamente, as ações de importância da Educação Popular em Saúde são desenvolvidas pela iniciativa dos profissionais, mesmo sem muito embasamento e direcionamento sobre o assunto, pela carência de protocolo específico do fluxo de trabalho para a condução das práticas no âmbito da EPS.

Palavras-chave: Educação. Saúde. Humanização da Assistência. Sistema Único de Saúde. Estratégia Saúde da Família.

COMPREENSÃO DE LA EDUCACIÓN POPULAR EN SALUD POR UN EQUIPO DE ESTRATEGIA DE SALUD DE LA FAMILIA

RESUMEN

Introducción: la Educación Popular en Salud (EPS), basada en Paulo Freire, busca reconocer y enfrentar los problemas de salud, por el diálogo con clases populares, respecto a las diferentes culturas y reconocimiento a la diversidad de los saberes. **Objetivo:** analizar el conocimiento sobre EPS de enfermeros y agentes comunitarios de salud (ACS) de la Estrategia Salud de la Familia de una Unidad de Atención Primaria a la Salud (UAPS) en Fortaleza, Ceará. **Método:** estudio cualitativo conducido por entrevista semiestructurada aplicada a cuatro enfermeras y cuatro ACS de la UAPS, con el fin de analizar la comprensión de los participantes sobre EPS. Los hallazgos fueron categorizados de acuerdo con el Análisis Temático de Minayo. **Resultados:** la mayoría de los profesionales trabaja entre dos y diez años en el servicio. Parte conoce los conceptos básicos de la EPS, pero no explicita aplicarlos cotidianamente. Gran parte relató falta de tiempo en las consultas, mantenimiento y construcción de los grupos y dificultad financiera para compra de materiales para actividades de EPS. Refirieron falta de humanización y enfoque biomédico-curativista. **Conclusión:** mayoritariamente, las acciones de importancia de la Educación Popular en Salud son desarrolladas por la iniciativa de los profesionales, pero sin mucha base y dirección sobre el asunto, por la carencia de protocolo específico del flujo de trabajo para llevar a cabo las prácticas en el ámbito de la EPS.

Palabras clave: Educación. Salud. Humanización de la Atención. Sistema Único de Salud. Estrategia Salud de la Familia.

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