



## HEALTH EDUCATION ACTIONS IN THE FAMILY HEALTH STRATEGY FROM THE PERSPECTIVE OF PROFESSIONALS

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### ABSTRACT

**Objective:** to identify health education actions carried out by teams of the Family Health Strategy, from the perspective of professionals. **Method:** qualitative and exploratory research, with teams from a Basic Health Unit in northwestern Paraná. Twenty professionals from the Family Health Strategy participated. Data collection took place in April and May 2021, through individual interviews, submitted to Bardin Content Analysis. All ethical precepts were respected. **Results:** among the participants, women predominated (90%), between 41 and 50 years (55%), community health workers (60%) and professional time from 6 to 10 years (65%). The professionals stated that the educational practices are aimed at the individual and the community. Those that are intended for the individual occur in the unit and in home visits, to meet their needs and clinical aspects, verbalized or observed by the professional, while those directed to the collective focus on the demands of programs and public policies. Participants prefer individual actions to collective ones. **Final considerations:** health education actions are part of the unit's work process, follow traditional pedagogical strategies, are carried out at various times of care and seek to meet the individual and population demands.

**Keywords:** Health education. Family health strategy. Health promotion.

### INTRODUCTION

Health education, a term used to name educational practices carried out with the population, is an important strategy to qualify self-care, since it aims to develop changes in the behavior of the individual, which result from the reflection and active participation of users in the care process<sup>(1)</sup>. It allows people to have enough information to choose healthier choices and modify their risk behaviors<sup>(2)</sup>.

Based on praxis, it contemplates the exchange of knowledge, criticality and socialized knowledge among all participants in the action, including users, families and professionals<sup>(3)</sup>. Educational practices should contribute to increase the autonomy of individuals and debates, using qualified listening and the joint construction of knowledge<sup>(1)</sup>, which is the conception of

educational action adopted in this study.

Thus, health education becomes an effective tool for health promotion and prevention of health problems developed by the Family Health Strategy (FHS)<sup>(4)</sup>, especially when it comes to the demands and needs of the users who follow it, transcending the biomedical model and meeting the integrality of the subject, according to their socioeconomic, cultural, psychoemotional and religious context<sup>(1)</sup>.

Due to the longitudinality of care, community insertion and first contact of users, the FHS is a privileged place for the development of educational actions, which can be used by health professionals to build links, access to the reality of users and effectiveness of team work<sup>(4,5)</sup>.

Thus, health education should be a routine, continuous and expanded strategy, present in

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every individual or collective activity performed, including the treatment and recovery of the user<sup>(3)</sup>. To this end, professionals should use the various resources and spaces available in health services and in the community, whether public or private, because such action is important to promote the quality of life and the development of daily tasks of people, enhancing the care<sup>(6)</sup>.

Thus, its development is of paramount importance for health promotion and disease prevention, once carried out in a systematic way and articulated with current policies. Still, it is preferable to meet the demands that emerge from the population, because, in this way, it becomes possible to approach the information of interest and experience of individuals, leading to greater participation of the population as protagonists of the educational process and health-disease.

Thus, the present study seeks to identify the health education actions carried out by FHS teams, according to the perspective of professionals, being outlined in response to the following guiding question: how are the health education actions by the FHS teams developed from the perspective of professionals?

## METHODOLOGY

This is an exploratory research of a qualitative nature, with structuring of the methodology according to the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) initiative.

The study scenario was a Basic Health Unit (BHU) of a municipality located in the Northwest region of Paraná. The BHU was selected for having the largest number of FHS teams in the city, totaling three teams, with 29 health professionals, including doctors, nurses, nursing technicians or assistants, community health workers (CHW), dentists and dental technicians or assistants.

The criterion for inclusion of participants was to work in the FHS for at least six months; excluding those who were away from their function in the period of collection. After applying these criteria, five professionals were excluded due to vacations and being a risk

group for Covid-19.

The approach with the participants occurred in a visit to the BHU, with presentation of the research and invitation to participate. For those who agreed to participate in the study, the best day and time for data collection was scheduled. Four professionals refused, and 20 participated in the study. Thus, the sample was defined by convenience and all available participants were contacted.

Data were collected through an individual interview, between the months of April and May 2021, on a day and time set by professionals, in the workplace, in a room that guaranteed their privacy. Only two interviews took place through audio messages from the WhatsApp® app, recorded sequentially by the participant and researcher, due to remote work during the Covid-19 pandemic. They were performed by nursing students, duly trained and supervised by professors who have proximity to this data collection technique.

The interviews were recorded in digital media, with the participants' consent, and had an average time of 35 minutes, the longest lasting 48 minutes. An instrument built by the researchers was used, containing a questionnaire to characterize the participants and a semi-structured script to guide the interview, consisting of the guiding question "Talk about your performance and experience in health education for the population?" and support issues for further information.

The characterization data of the participants were typed and organized in a spreadsheet. The qualitative data were transcribed in full in a Microsoft word® document and submitted to Bardin's Content Analysis<sup>(7)</sup>, which occurred in three stages.

The first was the organization, using floating reading procedures, hypotheses, objectives and elaboration of indicators to support the interpretation. The second one corresponded to the encoding of the data through the registration units. The last stage comprised the categorization, where the elements were classified according to similarities and differences, being regrouped by common characteristics. Thus, coding and categorization are parts of content analysis<sup>(7)</sup>.

All ethical and legal aspects were fulfilled in

the execution of this study, in line with Resolutions n. 466/2012 and n. 510/2016, of the National Health Council. This research has ethical approval under opinion n. 3.492.544/2019, and to maintain anonymity, participants were identified using the letter “P”, followed by a sequential number corresponding to the order of the interviews.

## RESULTS

Among the 20 participants, there was a predominance of females (90%) and aged 41 to 50 years (55%). They work in the profession between 6 and 10 years (65%), in the same period in Primary Health Care (PHC) (60%) and in the FHS team (55%). Most participants are community health workers (60%), followed by nursing technicians (20%), nurses (10%), dentists (5%) and dental assistants (5%). The medical category was the only one that did not participate in the research, due to the professionals' refusal.

The qualitative data resulted in two categories: “Health education focused on the individual and the community” and “Health education in the practices of PHC professionals”.

### Health education focused on the individual and the community

The participants, in their perceptions, identified that health education occurs at different times of the care offered, highlighting individual care in the service, such as nursing consultation, and home visits. Collective activities were also pointed out as a moment of health education, using mainly lectures and educational groups.

When talking about this health education, we imagine lectures in groups, smoker groups, groups of pregnant women, in short, the ones we develop. But in primary care, when a patient enters the room, in the nursing consultation, I do all the health education. (P1)

It [health education] takes place through educational lectures, groups, in individual guidance, in consultations both at the UBS and in home visits. (P20)

Health education aims to respond to the

person's needs and clinical condition, both verbalized by the user and identified by professionals as important for their health. Part of the interaction with the patient, based on the observation of the daily life of the population and the interest of each individual.

I talk about the issue of food education and care, right?! Such as physical activity, hydration, good sleep quality, optimal use of prescribed medications, the importance of preventive. (P1)

We identified the need for health education in the population's own interest. Because, so, when the patient has any doubts, when you are making a home visit, if there at the time he wants to know something, he ends up asking. (P4)

In direct contact with them, we get to know what they need. We identify on a daily basis, with those who are hypertensive, who do not take their medication properly. (P13)

When health education turns to the collective, subjects selected by the service or management are addressed, according to health programs and policies. In such cases, educational materials are available.

With the population, our role is to provide guidance on health: programs, vaccination, lifestyle and what the government also asks for. (P10)

We do a lot of speaking at reception with defined themes. We use brochures and flyers. We had a locker just with pamphlets, then we would go to the stores, in the commerce to pass on the information. (P12)

However, there is an understanding that carrying out health education actions defined by the higher authorities does not bring the best result, as they must contemplate the demand of the individual and the population assisted.

Look, I'll be very honest... We often know the demand in that area, in that place. We try to focus more on demand, but we have to work as it comes [from management] for us to work. And sometimes it's not always what they need. (P3)

I cannot do the same health education actions in the center and in a population on the periphery, they are different realities, so health education also has to be. Yes, include the parameters of programs and policies, protocols and the entire schedule of the state and municipality, but also include the reality of each one. (P14)

The professionals highlighted that they carry out educational actions as a means of health promotion and prevention of diseases. At times, it supports early diagnosis and allows the recognition of signs and symptoms.

I believe that it is through health education, raising awareness, guiding and working with preventive care of diseases that we will achieve better quality in health.. (P20)

We explain, talk, to patients. We work with prevention; it is not treating the disease. It has happened that the person thinks there is nothing, then you give guidance, speak in a group, right? Then you find out, the person thought they had nothing and had. (P13)

Health education focused on prevention, promotion and screening are common in community care, and professionals use social devices as external partners to develop them.

We go to school and provide school care for children from first to fifth grade at the municipal school and at the state school with teenagers. It does together the application of fluoride, the mouthwash, and teaches. (P16)

We do this work of guiding, while measuring blood glucose or other procedures. (P13)

### **Health education in the practices of PHC professionals**

This category revealed that professionals assume a posture that can facilitate the performance of health education, or even hinder it.

The commitment of professionals seeking alternatives to provide effective communication with the population and for the intended behavior change stands out.

A positive point is the insistence of the professional. If we see the patient ten times, ten times you hit the same key, until he understands the problem he has. (P8)

We serve immigrants, many Haitians and Venezuelans, so we try to make ourselves understood, put it on Google translator®. (P1)

Still, there is the willingness of the team to take advantage of the various moments and actions developed by the service to carry out health education, even when these have other

purposes.

I use every moment to teach what I know. If you're on the street measuring blood pressure, it's easier to hand out a pamphlet and give guidance. Then you already approach him in his need. Or, sometimes, here at UBS, while waiting for the appointment, they are more receptive. (P12)

When the patient has any doubts, when you are visiting his house, during home visits, if he wants to know something at the time, he ends up asking. And I take the opportunity to do health education. (P4)

Finally, it was possible to identify that some professionals do not understand themselves as responsible for health education, attributing it as a function of colleagues and other professional categories, or justifying this by not participating in preventive activities.

This part of guidelines, groups, educational actions we do not do. They are performed by nurses. (P2)

Who else does these actions are the CHW, right? They are more prepared to be advising, they are the ones who stay with the family, who go to the patient's house. We do not. We only go, like, when, it's already a more healing thing. (P9)

### **DISCUSSION**

In this study, it was possible to identify that, in the perception of FHS professionals, that health education actions of the population are present in the work process of the teams at various times of health care. Corroborating the results, a survey conducted with nurses in the city of Manaus demonstrated that health education occurs in different ways, either individually or collectively, with programmed actions or spontaneously, in response to the demands of the moment<sup>(8)</sup>.

When performed in individual care, educational practices are better accepted by the population, since in this format they respond more clearly to their health needs and conditions. Nevertheless, there is resistance when actions happen concomitantly to another service that the user looks for in the unit, such as waiting for consultations, medicines and procedure, especially when access to this is limited, since the biomedical and curative

model is still rooted in the population<sup>(9)</sup>.

The professionals highlighted the moments of individual contact with patients as a possibility to perform health education, citing nursing consultation and home visit as examples. This pointing may result from the predominance of CHW and the nursing team among the research participants, since these services are part of the daily lives of these professionals<sup>(10,11)</sup>.

A study showed that the nursing team, as well as several technical and higher level professionals, still prioritizes clinical care during their practice, including during home visits, to the detriment of specific health education actions. However, during consultations and procedures, they can be implemented, complementing the care offered, based on the specificities of the user and his family, as well as the reality in which it is inserted, with the home visit being the ideal locus for this<sup>(10,11)</sup>.

Nurses and nursing technicians usually perform few health education actions aimed at the collective, as these are overlooked in the face of other demands of the service and its devaluation in the work process. This reality changes when there is a need to perform procedures in the groups, such as blood pressure measurement<sup>(10)</sup>.

Still in the context of educational actions directed to the individual, the home visit, cited by the participants at different times, can be anchored in the fact that the CHW, most of the participants, has an important role in its realization. Research conducted with these professionals demonstrated that, in addition to systematically conducting visits in their daily routine, they consider it an essential moment to improve the health conditions of the population. To this end, the educational dimension of this moment has to be frequent and stand out from the other actions performed at home<sup>(12)</sup>.

It is important to note that, as a powerful tool of health education, home visits should be implemented by the entire multidisciplinary team. It provides proximity to the experiences and daily life of individuals, generating a fertile space for dialogue and knowledge exchange, becoming an effective strategy for the promotion and prevention of health problems

for the population<sup>(13)</sup>.

Also, actions developed collectively were pointed out. For PHC, this is a valuable tool in health education. Activities carried out with groups of people, such as lectures and conversation circles, facilitate the dissemination of information and reach a large number of individuals at once, as well as being a tool for the exchange of experiences between the users and professionals<sup>(14)</sup>.

Educational actions are common in groups with populations organized according to their disease or health program to which they are linked, executed through lectures. In these cases, the lecture is highlighted as one of the main tools used, even if it is a traditional teaching approach, in which only the transmission of information occurs, without stimulating the reflection and inclusion of users in the educational processes, which meets the premises of health education<sup>(8)</sup>.

Sometimes, the groups formed, initially, for the development of educational actions in health can, at some point, lose this objective, turning only to the treatment of the disease common to the collective, and not in the promotion of the health of individuals. This was evidenced in a study that identified that, in the hypertensive and diabetic group, health education actions did not occur, but focused on care<sup>(9)</sup>.

The actions, collective or individual, which contemplate only the guidelines listed by the professionals, demonstrate an attempt at verticalized health education, focused on the behavior change selected by the health team or by public policies. Thus, they focus on injuries, with standardized guidelines that tend to blame or coerce participants for behavior change instead of stimulating reflection, promoting dialogue and offering support<sup>(8,9)</sup>.

The participants of this study did not bring in their reports, explicitly, the realization of only verticalized and imposed actions, but reported that the activities are focused on issues that users need to change in their life, as food, physical activity and drug use. Nonetheless, guiding actions on specific and vertical themes usually does not stimulate reflection by users of habits and the need for modification. Thus, the team must use tools that make the individual

active in decisions related to their health, developing their autonomy<sup>(15)</sup>.

It is necessary that professionals rethink their educational practices, using pedagogical techniques that enable dialogue and share information, stimulate criticality and contribute to the construction of new postures and knowledge, resulting in a new understanding of health-disease. Thus, meeting the demands of the population becomes more effective, since it is part of the real interests of individuals<sup>(8)</sup>.

Participants verbalized the direction of health education to meet the demands that arise from the population, as well as to contemplate those required by health policies and programs. For educational actions to be effective, they must be planned considering the epidemiological, social and cultural profile of the population and their health conditions. With this, one can interfere in an appropriate way for the improvement of the health situation of each individual and the collectivity, in an individualized way and articulated to the real needs<sup>(16)</sup>.

In this context, the actions developed, whether individually or collectively, need to be built by professionals through territorialization and local indicators. It is up to the entire FHS team, guided by the knowledge of the CHW, who are in constant contact with individuals, to evaluate the territory and understand the needs of that particular area, in order to list health needs and plan educational actions<sup>(15)</sup>.

Actions aimed at health education are consistent with health promotion and prevention activities directed to the community. Preventive and promotion actions allow educating and raising awareness among people; thus, educational practices impact on changing habits and users' autonomy<sup>(17)</sup>.

Starting from this look of avoiding illness, present in several speeches, it is possible to observe an intertwining in meeting individual demands and health policies and programs, so that the identification of those is influenced by the approach of professionals to the procedures, problems and priority groups most prevalent in their daily work, which arise from health policies and programs running in the service. Thus, even when professionals seek to meet the demands of the individual, their perception may

be impaired by the limitation of knowledge, which is structured in the subjects most discussed and present in the service and in the collective. This needs to be modified in the reality of services, so that individual demands can be really considered, evidencing the need for permanent education in PHC<sup>(9)</sup>.

The previous and permanent training of professionals who work daily with this process of education becomes a strong point to qualify the assistance<sup>(6)</sup>. Investing in problematizing permanent education, which allows professionals to expose their difficulties, discuss them and learn them, is essential to transform the work process and the health education they offer<sup>(18)</sup>.

The FHS professionals are dedicated to including educational actions in their daily lives, even without receiving training and guidance on how to carry them out, demonstrating that the lack of permanent education is not a reason for the absence of health education<sup>(19)</sup>. However, this fragility of training may reduce the amount or effectiveness of these actions, or delegate such activities to a specific professional category<sup>(6)</sup>. This can be seen in the speech of a participant, who claims not to perform health education, since another professional category receives training for this.

The lack of permanent education for the development of educational actions with the population and the perception that there are professional categories aimed at the development of these are weaknesses that directly affect health education. Such actions are not the sole responsibility of a professional or any professional category, but of all who make up the health team. Multiprofessional work is essential for comprehensive care, which is stimulated by knowledge from various categories, promoting the success of educational actions, facilitating and qualifying such process<sup>(20)</sup>.

The participants pointed out some potentialities in the development of health education, such as the involvement of professionals, the use of various moments for its realization and the search for alternatives so that the action is effective. Some motivated professionals seek, even with few resources and infrastructure, to carry out high-level and

comprehensive activities. Using only the means available to the community, they seek to overcome barriers and bring improvements to the quality of life of users<sup>(21)</sup>.

Moreover, it is worth listing that health education requires that the professional go beyond the link with users and knowledge of the territory, requiring creativity of those who produce it. It is necessary to increase new practices, new ways that call the attention of users of the service, that bring them closer to knowledge and awaken the desire to act for their health and express themselves<sup>(21)</sup>.

Therefore, co-management should be used and prioritized, so that the planning of health actions, including educational ones, is participatory and in accordance with the needs of the population<sup>(8)</sup>. Furthermore, investing in participatory methods for health education is the key to promoting popular participation. With these, exchange of information and the understanding that the individual is active in their health care are promoted, being able to transform their quality of life and the health-disease process<sup>(22)</sup>.

## FINAL CONSIDERATIONS

This study allowed identifying that health education performed by FHS teams occurs both individually and collectively. Still, professionals are attentive to the needs of the

population, having greater preference for actions that respond to these demands than those developed for the care of programs and health policies to specific groups.

Health professionals understand that it is essential to carry out health education at various times, and strive to do so, since this provides changes in lifestyle and helps identify risk factors. However, some still have weaknesses in the planning and execution of educational actions, believing that they do not have responsibilities to this action.

Finally, FHS professionals need to transcend the barriers and traditional practices related to health education in order to bring the population to health services, especially with regard to collective actions. In this way, it will be possible to jointly build health actions that prioritize comprehensive care and encourage health promotion and prevention of diseases.

Regarding the limitations of this study, the fact that it was performed in only one BHU is noteworthy, and it is important to expand to other health services, to better understand the perception of health education of different professionals and different services. More studies addressing the theme and evaluating the educational actions should be carried out to contribute to the production of scientific knowledge that qualifies the care practice and nursing care.

## AÇÕES DE EDUCAÇÃO EM SAÚDE NA ESTRATÉGIA SAÚDE DA FAMÍLIA NA PERSPECTIVA DOS PROFISSIONAIS

### RESUMO

**Objetivo:** identificar as ações de educação em saúde realizadas por equipes da Estratégia Saúde da Família, na perspectiva dos profissionais. **Método:** pesquisa qualitativa e exploratória, com equipes de uma Unidade Básica de Saúde do noroeste do Paraná. Participaram 20 profissionais da Estratégia Saúde da Família. A coleta de dados aconteceu em abril e maio de 2021, por meio de entrevistas individuais, submetidas a Análise de Conteúdo de Bardin. Todos os preceitos éticos foram respeitados. **Resultados:** dentre os participantes, predominaram mulheres (90%), entre 41 a 50 anos (55%), agentes comunitários de saúde (60%) e tempo de atuação profissional de 6 a 10 anos (65%). Os profissionais afirmaram que as práticas educativas são voltadas ao indivíduo e a coletividade. As que se destinam ao indivíduo ocorrem na unidade e nas visitas domiciliares, para atender suas necessidades e aspectos clínicos, verbalizados ou observados pelo profissional; já as dirigidas ao coletivo enfocam as demandas dos programas e políticas públicas. Os participantes preferem as ações individuais em vez das coletivas. **Considerações finais:** as ações de educação em saúde integram o processo de trabalho da unidade, seguem estratégias pedagógicas tradicionais, são realizadas em diversos momentos da assistência e buscam atender as demandas individuais e da população.

**Palavras-chave:** Educação em saúde. Estratégia saúde da família. Promoção da saúde.

## ACCIONES DE EDUCACIÓN EN SALUD EN LA ESTRATEGIA SALUD DE LA FAMILIA DESDE LA PERSPECTIVA DE LOS PROFESIONALES

## RESUMEN

**Objetivo:** identificar las acciones de educación en salud realizadas por equipos de la Estrategia Salud de la Familia, desde la perspectiva de los profesionales. **Método:** investigación cualitativa y exploratoria, con equipos de una Unidad Básica de Salud del noroeste de Paraná/Brasil. Participaron 20 profesionales de la Estrategia Salud de la Familia. La recolección de datos ocurrió en abril y mayo de 2021, a través de entrevistas individuales, sometidas al Análisis de Contenido de Bardin. Todos los preceptos éticos fueron respetados. **Resultados:** entre los participantes, predominaron mujeres (90%), entre 41 a 50 años (55%), agentes comunitarios de salud (60%) y tiempo de actuación profesional de 6 a 10 años (65%). Los profesionales afirmaron que las prácticas educativas son dirigidas al individuo y a la colectividad. Las que se destinan al individuo ocurren en la unidad y en las visitas domiciliarias, para atender sus necesidades y aspectos clínicos, verbalizados u observados por el profesional; ya las dirigidas al colectivo enfocan las demandas de los programas y las políticas públicas. Los participantes prefieren las acciones individuales a las colectivas. **Consideraciones finales:** las acciones de educación en salud integran el proceso de trabajo de la unidad, siguen estrategias pedagógicas tradicionales, son realizadas en diversos momentos de la asistencia y buscan atender las demandas individuales y de la población.

**Palabras clave:** Educación en salud. Estrategia Salud de la Familia. Promoción de la salud.

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