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Health education in practice from the perspective of professionals in rural areas of a small municipality in Minas Gerais

A prática da educação em saúde na perspectiva de profissionais da zona rural de um município do interior de Minas Gerais

La práctica de la educación en salud en la perspectiva de profesionales de la zona rural de un municipio de Minas Gerais

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ABSTRACT
Objective: to describe the health education actions performed by Family Health Strategy personnel in rural area of a town in Minas Gerais. **Method:** this exploratory, qualitative study involved 16 Family Health Strategy personnel from a rural area. Data were collected through semi-structured interviews in 2019 and analyzed using content analysis. **Results:** three thematic categories emerged: Health education, disease prevention and information transmission; Health education as a synonym for in-service education; and Work management as a tool for health education. **Conclusion:** health education is carried out through group or individual lectures. It is disease-focused and rests on conveying professional knowledge. It is still perceived as in-service education, revealing health personnel's lack of knowledge on the subject. There was found to be a need to invest in management when enabling funding and agents for health education.
Descriptors: Primary Health Care; Family Health Strategy; Health Education; Rural Areas.

RESUMO
Objetivo: descrever as ações de educação em saúde realizadas por profissionais da Estratégia Saúde da Família da zona rural de um município do interior de Minas Gerais. **Método:** estudo exploratório, abordagem qualitativa. Envolveu 16 profissionais da Estratégia Saúde da Família da zona rural. Coleta de dados realizada por meio de entrevistas semiestruturadas em 2019, com dados analisados empregando técnica de análise de conteúdo. **Resultados:** emergiram três categorias temáticas: Educação em saúde, prevenção de doenças e transmissão de informações; Educação em saúde como sinônimo de educação em serviço; e, A gestão do trabalho como ferramenta para a educação em saúde. **Conclusão:** a educação em saúde é realizada por meio de palestras, grupos ou individualmente, focada na doença, ancorada no repasse de saberes profissionais. Ainda é percebida como educação em serviço, revelando desconhecimento dos profissionais frente à temática. Constatou-se necessidade de investimento da gestão na viabilização de recursos e agentes para a educação em saúde.
Descritores: Atenção Primária à Saúde; Estratégia Saúde da Família, Educação em Saúde; Zona Rural.

RESUMEN
Objetivo: describir las acciones de educación en salud realizadas por profesionales de la Estrategia Salud de la Familia en el área rural de un municipio del interior de Minas Gerais. **Método:** estudio exploratorio, abordaje cualitativo. Involucró a 16 profesionales de la Estrategia Salud de la Familia, en áreas rurales. La recolección de datos se realizó a través de entrevistas semiestructuradas en 2019, los datos se analizaron mediante la técnica de análisis de contenido. **Resultados:** surgieron tres categorías temáticas: educación en salud, prevención de enfermedades y transmisión de información; Educación en salud como sinónimo de educación en servicio y la Gestión del trabajo como herramienta de educación en salud. **Conclusión:** la educación en salud se realiza a través de conferencias, en grupo o individualmente, enfocada a la enfermedad, anclada en la transferencia de conocimientos profesionales. Todavía se percibe como educación en servicio, lo que revela la falta de conocimiento de los profesionales sobre el tema. Se percibió la necesidad de invertir de la gestión en hacer viables los recursos y agentes para la educación en salud.
Descriptores: Atención Primaria de Salud; Estrategia de Salud Familiar; Educación en Salud; Medio Rural.

INTRODUCTION

Primary Health Care (PHC) allows individuals and communities to express their needs and problems. It represents the gateway to the system and aims at providing comprehensive care[1,2]. In PHC, the Family Health Strategy (FHS) represents a space for the incorporation of health promotion practices, with the qualification of the community to develop autonomy and self-care, which is made possible by teamwork[3].

In order to overcome the biomedical model, health promotion represents a transformative process, presupposing reorientation of the health services, considering political dimensions, maturation of personal/collective skills, community involvement, and care with the environment[4,5].

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Education in health represents one of the tools for health promotion, proposing approximation and bonding of individuals/families/communities to the health services. The educational practice must contribute to the development of the user's autonomy, enabling the reconstruction of habits and greater participation in decision-making. However, a number of studies indicate that the health education actions are still limited to the conduction of groups, with users and focused on diseases[6-8].

From the emancipatory perspective, education in health is based on the dialogical and problematizing model, allowing for the transformation of the individuals' behaviors and habits in relation to health. This model makes it possible for the individual/community to reach autonomy and a critical, reflective view on reality, providing a greater impact on the health indicators and on quality of life[9-11].

When considering the rural area, the population has the FHS service as its only gateway to the system. Such community experiences vulnerability and health problems related to precarious housing conditions, low schooling level, and difficulty accessing to the health units. The panorama is complex and hinders the health team's performance[12].

Due to the various difficulties experienced by the community and to the gaps in the scientific production about the theme, the following question is raised: Which health education actions are developed in the daily work of the rural FHS, considering the local, social and cultural reality in which this community is inserted?

Given the above, the objective of this study was to describe the health education actions performed by Family Health Strategy professionals from the rural area of a municipality in the inland of Minas Gerais, Brazil.

THEORETICAL FRAMEWORK

In order to analyze the practice of education in health in the FHS/rural area, the findings were approached to the work process in health. This is justified by the fact that the theme in question is complex in everyday life, being influenced by the care model and by work organization.

The theory of the work process in health represents an important theoretical-conceptual approach regarding human resources. It considers how the work is performed and intends to elaborate a specific product[13]. The work process, which is not static, translates the way in which it is performed, by means of actions on certain object, obtaining a given product[14].

The most important components of such process are the object (what will be transformed); material and non-material instruments; agents (professionals); and purpose[13]. Such elements must not be analyzed separately, as they require a reciprocal relationship to configure a work process[15].

It is fundamental to consider the dynamic and relational dimensions of the aforementioned process, which are necessary not only as a sociability structure, but also as an interpersonal practice that modifies that society[13].

Education in health is permeated and influenced not only by its conceptual aspects, but fundamentally by the design and the organization of the work process in health in the rural area, as well by the professionals' perception about the theme and their practice.

METHOD

An exploratory study with a qualitative approach was conducted in 2019 with the professionals working in four FHS/rural area teams from a municipality in the inland of Minas Gerais, Brazil. The criteria set forth in the Consolidated criteria for reporting qualitative research (COREQ) were followed. Such instrument includes three domains: research team and reflexivity, study design, and analysis/results. It aims at targeting important aspects of the research, ensuring its reliability[16].

At the time of data collection, the four teams had 55 professionals: 25 community health agents, seven nursing technicians, six physicians, five dental surgeons, five oral health assistants, four nurses, and three psychologists.

The intention was to interview one professional per category and per team. Of the 55 professionals, after inclusion of those who were the only one in their professional category and who met the inclusion criterion, i.e., working at the team in question for at least six months, there were draws for the categories that had more than one professional in the team, which yielded a population consisting of 27 eligible professionals. It is noted that no draw was conducted regarding the categories that had only one professional in the team. The professional was included if they met the inclusion criteria. Draws were made when the professional category had more than one professional in the team. This occurred with the intention of having one professional per category in each of the four FHS/rural area teams.

According to the exclusion criteria, from the 27 professionals, 11 were excluded; of which four had a working time below six months, four were away from work at the time of data collection, and three were not found after three attempts to schedule the interview, totaling a final population of 16 intentionally selected participants. Regarding the

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professionals excluded, there was no possibility to recruit other agents, as they were the only ones belonging to the category in the team.

Data collection took place from May to September 2019, by means of semi-structured interviews guided by a script that was assessed by three individuals with PhDs in the theme and/or in research methodology. The script included sociodemographic data and aspects about the practice of education in health, from the professionals' perspective. A pilot test was conducted with two nurses who worked in PHC but not in the FHS, in order to test the data collection instrument in real conditions prior to definitive data collection. With the pilot test, it was verified that it would not be necessary to implement any adjustments in the script for the interview.

The interviews were conducted by the researcher herself, an undergraduate Nursing student, having been previously trained by the research supervisor. The interviews, which were audio-recorded in a digital media, were conducted face to face at the FHS unit on a previously scheduled day during the professionals' working hours, in common agreement between the participants and the researcher and in a room that ensured privacy. The interviews were then transcribed in full by the researcher, with no participation of external analysts. They lasted a mean of six minutes. During the interview in the private room, only the researcher and the interviewee were present. Contact between researcher and participant occurred in person at the unit, after the researcher introduced herself, provided the justification for the research, and made the invitation. Whenever possible, the interview was conducted on the same day, or at an agreed upon date. The participants were identified as E1, E2, and so on up to E16, with the letter I indicating interviewee ("*Entrevista*" in Portuguese) and the numeric sequence indicating the order of the interviews.

The data referring to the interviewees' characterization were submitted to descriptive analysis. Methodological guidance was employed in the thematic modality of content analysis for the qualitative data, with development of the following stages: Pre-analysis (exhaustive reading of the material collected to identify thematic units); exploration of the material (compilation of the thematic categories that emerged by grouping context units, by affinity); treatment of the results and interpretation of the material (construction of the dialog between study findings and theory)[17].

This research complied with Resolution No. 466/12 of the National Health Council, being approved by the institution's Research Ethics Committee. It is part of a larger project entitled: "Perception of education in health in Primary Health Care". The participants signed the Free and Informed Consent Form.

RESULTS AND DISCUSSION

Among the 16 participating professionals, there were four community health agents (25%), three oral health assistants (18.75%), three dentists (18.75), three nursing technicians (18.75%), one nurse (6.25%), one psychologist (6.25%), and one physician (6.25%). Of the total, 14 (87.50%) were female and two (12.50%) were male. Their age varied between 26 and 63 years old, with a mean of 47.3. The professional training time was from one to 40 years; and one person did not report this information. The participants' working time in the team varied from two to 23 years, with a mean of nine years.

During the process to compile the categories, the findings that emerged from the analysis were grouped by content affinity into three thematic axes: Education in health, prevention of diseases and transmission of information; Education in health as a synonym of in-service education; and Work management as a tool for education in health. There was no subdivision into categories.

Education in health, prevention of diseases and transmission of information

The thematic category evidences that education in health is developed by means of groups and lectures with the users, being emphatically revealed. The professionals also delivered education in health during the individual appointments, and the actions were focused on the disease, occurred in a systematized manner with previous planning and on a predefined day and time.

According to the participants, education in health occurs by assembling groups with the users, with specific audiences as recommended by the Ministry of Health, following a normative, standardized and often prescriptive logic. Education in health is not understood as something that permeates the work process but as another stage to be completed:

> *We have the health in the school programs groups, in which we perform some activities, and there's the Hiperdia group. (E5)*
>
> *Yes, sometimes (...) there are groups with hypertensive people, groups of babies with their mothers, with pregnant women and (...) sometimes there aren't! The entire month I go to the schools offering education in health. (E10)*

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> *With the patients, we provide some guidance (...) promote lectures, assemble groups, talk about the disease. Not only me, all of us here do so (...) sometimes, people are in the waiting room, then we talk with them (...) today we're going to talk about tuberculosis. (E15)*
>
> *Once a month we perform activities in the rural area and in the schools and companies too, then we follow the Ministry of Health schedule, each season. Yellow September, for example (...) Besides that, we schedule things according to the Secretariat, some more convenient themes, and then we present these themes to them. (E16)*

The education in health activities performed in the FHS/rural area grounds the actions with specific groups, focused on diseases and health problems. This result converges with the literature when evidencing that the development of groups represents the main educational practice in PHC[18].

However, it is worth noting that the groups for the practice of education in PHC must address themes previously suggested by the users, related to health promotion and disease prevention, and not be focused only on the diseases, a fact that has not been evidenced. The traditional model of groups still remains, based on the disease and on the curative perspective, revealing challenges to be overcome in the practice of education in health[18,19].

The reports evidenced the perception of education in health as another stage of the work process. It is not perceived as the guiding thread that permeates the entire conduction of work. According to the agents, education in health must be programmed, scheduled and aimed at a specific audience.

The findings reveal a shared identity that education in health represents a separate task, different from the work process. Such results converge with those found in the literature, which asserts that this practice of education in health, characterized by punctual actions and aimed at specific areas, is quite common[20] in the daily routine. However, it is asked why not to conduct education in health in all and any professional-user interactions, transforming this encounter into a space for exchanging and sharing knowledge.

In this sense, professional training, by reinforcing the biomedical model and the work process in health, does not consider the profile, the demands and the anxieties of the community as guiding axes to subsidize health education actions that converge with social reality. This practice is of little help in the conduction of integral actions and does not collaborate to the recognition of the needs of each user and of the community[21].

The participants reported conducting health education actions in the individualized care of users, in the home visits or in FHC, with an emphasis on disease prevention and on the vertical transmission of information from professional to user:

> *Every Thursday (...) and also in the visits, you know? Advising people on health care, the preventive tests (...) on vaccines, seeing the doctor at least once a year. (E6)*
>
> *We provide information, we work with the patient both here in the unit (...) and in our home visits. So, what we most provide over these visits or even here is information, and I believe that education is information over education, without it you wouldn't be able to provide (...) information on how to act in those situations or in their prevention. (E8)*
>
> *I always choose a theme and in the visits we make the routine and follow-up visit and then talk about some theme (...) this month we're talking about the Pap smear test (...) We're advising women, we're handing a booklet on how the test is made (...) each month we work on something. (E14)*

When education in health is considered as an instrument for prescriptions and limits, defining what is right and wrong with regard to the individual's own health, it is difficult to perceive the expended concept of health, which goes beyond the presence or absence of diseases[22]. The social and dynamic nature of health and all it involves does not enter into discussion in the paradigm of transmission of technical knowledge and hegemony of professional knowledge. It is fundamental that the agents of the work process use non-material instruments in the health education actions, based on the welcoming perspective of the users' non-systematized knowledge.

Individual autonomy, protagonism, appreciation of popular knowledge in health care, and co-responsibility of the subjects in their own therapeutic project must permeate health education actions, from an emancipatory perspective. Health care must collectively involve professionals and subjects, considering that the practice of welcoming, through listening and dialog, strengthens the relationships between them, making them more horizontal[23].

Education in health as a synonym of in-service education

Another meaning that emerged in the testimonies evidences education in health as actions developed together with the professionals, being expressed, by them, as continuing education and team meetings. Education in health is perceived as a synonym of in-service education:

> *Continuing education that we do every month [referring to education in health], which we also do here twice a month. We always address the common diseases that we find in the farms. (E3)*

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> *We perform continuing education (...) [referring to education in health] right, the frequency is once a week, but sometimes, when certain professionals go on vacation (...) they can have some spacing (...) we do it every 15 days, but we always hold a meeting at least once a month. (E4)*
>
> *We do it once a week, for about an hour (...) [referring to education in health]. We hold meetings and discuss administrative themes and (...) those required by the Health Secretariat, by the Ministry of Health, and also themes proposed by the team itself (...) these meetings are administrative but also of education in health. (E5)*

For the participants, when they hold meetings to discuss administrative issues or those focused on the diseases, they are developing education in health. The testimonies explained the shared meaning of education in health as a synonym of in-service education.

The findings differed from the literature, which highlights education in health as an action performed between professionals and patients/community, involving exchange of knowledge, construction of bonds, knowledge about diseases and promotion of self-care[24,25], valuing the individual's ability[7].

The testimonies evidenced continuing education as education in health. According to the literature, continuing education is a teaching and learning process aimed at the active and permanent development of the professionals[26]. This mixture of concepts and meanings between education in health and continuing education reflects lack of professional knowledge, compromising its understanding and the implementation of emancipatory practices in health[27].

Work management as a tool for education in health

The professionals from the FHS/rural area expressed strategies and proposals for education in health, contemplating from the conduction of lectures to the need for availability of material instruments related to the work process, as well as infrastructure of the unit.

The interviewees proposed that the professionals should conduct more education activities in groups and lectures addressing specific themes and aimed at the community, with an emphasis on disease prevention. The reports revealed to be impregnated by the biomedical model and transmission of professional knowledge to the user:

> *There are no lectures here, some lecturers (...) those about sex, about drugs, there's nothing like this here. It is talking about the disease, diabetes, hypertension. (E1)*
>
> *Calling more people to join the groups, assembling more groups. (E2)*
>
> *We had to build a strategy for the group to be resumed, at least that thing in the waiting room. You know? Taking the opportunity that there is people there waiting to be seen by the doctors and perform (...) some prevention with them right there (...) in the reception room. (E6)*

The findings reinforce the practice of education in health based on assembling groups with the users, focusing on disease prevention and on different themes with qualified lecturers. This suggestion converges with the literature when indicating that, in the groups, the individual finds support to face individual/collective problems[7,28]. The potential of education in health as a dialogical and emancipatory practice coherent with social and health demands stands out, especially in the FHS/PHC scenario, which envisions a close proximity between professionals and community. The educational practice allows for exchange of knowledge among their participants and the possibility of listening to the others and establishing horizontal relationships, favoring the subject's autonomy[29].

Education in health still remains vertical, in line with the literature, considering the professionals as those who provide and convey information, with the purpose of disease prevention[30]. Thus, the need stands out for an organizational culture that promotes activities based on continuing training and guidance[31].

In order to facilitate the practice of education in health, some interviewees pointed to the need of improving infrastructure of the unit and availability of material resources. According to them, they sometimes use own resources to develop the actions. A close relationship between the practice of education in health and the components of the work process is evidenced, especially, material instruments:

> *A [suggestion] is this: paying special attention to devices in public squares, where you can develop something more specific (...) the inputs to measure glucose levels, the devices to measure BP (...) health care is then optimized. (E4)*
>
> *We'd need more space, a room for the meetings [with users], but ok it won't do any good. (E6)*
>
> *So, if we had more transportation, allowing us to go where the patient is or to bring the patient to us (...) if we could have a car every day. (E7)*
>
> *We lack a slide projector, equipment, a room (...) we've used the school when it is available, so we've been using the most basic resources, some poster that we design ourselves, a T-shirt, our own resources indeed, no resources from the municipality (E16)*

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The testimonies reveal that the material instruments of the work process are powerful tools for the appropriate implementation of education in health in the FHS/rural area context. Such findings converge with the literature, which addresses that the work process agents use their own financial resources to perform educational actions and strive to divide their time into activities in the health unit and in the communities[22,32].

However, as long as there is a limitation in material resources, education in health includes different actions that would waive the use of high-cost resources. The use of soft and soft-hard technologies would make its practice feasible. Effectiveness of education in health can achieved by means of constructing bonds, emphasizing the social reality, integrating professionals and community, and considering the population as a social subject and a protagonist in health care[33].

Study limitations

With regard to limitations, although the study reflects the local reality and its findings cannot be generalized, it is believed that they are very close to those of other locations in the country. We do not intend to exhaust the theme, but to subsidize new research studies on the theme proposed, considering the work process as a key element in this construction and practice.

CONCLUSION

It was evidenced that education in health is performed by means of lectures, groups, or individually with each user, emphasizing disease prevention or coping with a health problem. Generally, it occurs in a systematized and standardized manner, from a vertical perspective, grounded on the transmission of information from the professional to the user/community. It is perceived as a synonym of in-service education, revealing lack of pertinent assumptions to operationalize the work process in view of the theme.

Considering the singularity of the rural area, it is important to implement innovative educational practices that insert this community, which is excluded due to geographical, cultural and economic reasons, into health promotion actions and reconstruction of meanings and concepts. It is fundamental to carry out education in health actions that promote the users' protagonism and empowerment.

As a contribution, the urgency of a greater investment from the management on the availability of material resources, infrastructure and agents for the provision of education in health is pointed out. It is suggested that the management appropriates the findings to rethink work organization in order to effectively implement education in health in the rural area.

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