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Original Article

Concepts and practices of health education in primary care*

Concepções e práticas de educação em saúde na atenção primária

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ABSTRACT

Objective: to understand the conceptions and practices of health education among professionals in the Family Health Strategy. **Methods**: a qualitative study was carried out with 27 professionals from seven family health teams. Data was collected using individual audio-recorded interviews, a form, and notes in a field diary. The data description followed the transcription and analysis stages, utilizing the content analysis technique. **Results**: the concept of health education was presented as guidance, promotion, prevention, self-care, and access to health resources. It is practiced in visits, lectures, consultations, and encouraging participation in programs and groups. The motivations, challenges, facilitating aspects, and themes were discussed. Regarding the effects, they discussed clarifying users' doubts, implementing promotional actions, and providing guidance on local programs and issues. **Conclusion**: health education is carried out in accordance with the unit's routine health actions and with limited user participation. **Contributions to practice**: a report was produced for the participants, and a technical note was provided for managers with recommendations for improving health education in primary care.

Descriptors: Health Education; Primary Health Care; National Health Strategies; Health Promotion; Health Personnel.

RESUMO

Objetivo: compreender as concepções e práticas de educação em saúde entre profissionais da Estratégia Saúde da Família. **Métodos**: estudo qualitativo, realizado com 27 profissionais de sete equipes de saúde da família. A coleta de dados ocorreu com entrevista individual audiogravada, aplicação de formulário e anotações em diário de campo. A descrição dos dados seguiu as etapas de transcrição e análise, utilizando a técnica de análise de conteúdo. **Resultados**: a concepção de educação em saúde foi apresentada como orientação, promoção, prevenção, autocuidado e acesso aos meios de saúde. Sua prática acontece nas visitas, palestras, consultas, incentivo à participação nos programas e grupos. Foi comentado sobre as motivações, desafios, aspectos facilitadores e temáticas. Sobre os efeitos, falou-se do esclarecimento de dúvidas dos usuários, ações de promoção e orientações dos programas e agravos locais. **Conclusão**: a educação em saúde é desenvolvida de acordo com ações de saúde da rotina da unidade e com limitado alcance de participação do usuário. **Contribuições para a prática**: elaborada devolutiva para os participantes e nota técnica para gestores com recomendações para o aprimoramento das ações de educação em saúde na atenção primária.

Descritores: Educação em Saúde; Atenção Primária à Saúde; Estratégias de Saúde Nacionais; Promoção da Saúde; Pessoal de Saúde.

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Introduction

Primary Health Care is a fundamental strategy in health systems that, through the Family Health Strategy, aims to prioritize health promotion, prevention, recovery, and education in a comprehensive and coordinated manner. It is also guided by essential attributes such as first-contact care, longitudinal comprehensiveness, and coordination of care, as well as seeking to meet the needs of the population, thereby guaranteeing continuous and comprehensive access to health[1].

In the 20th century, health education practices emerged in Brazil. Still, their main characteristics were to implant moral norms and behaviors, as well as habits of social interaction and hygiene, leading to an imposed adaptation in the lives of individuals[2].

However, health education consists of an aggregate of knowledge and learning, designed to provide individuals with an improvement in their state of health, motivating them to participate in the care process, improving the practices carried out, and promoting collective well-being[3].

Health education can also be considered as guiding specific subjects, which often do not focus on the real needs experienced by the population daily. To educate in health, it is necessary to know the interests of the users, providing them with knowledge that is inserted in the context of their daily activities[2]. It is essential to combine information, education, and communication actions, and for these to make a significant contribution to the conversation and participation with the community as they interact in the process of social transformation or change of a phenomenon[4].

Although health education is an activity with a substantial theoretical basis, its use in health services is lower than desired[5]. For health education to be effective, the professional must have a broad understanding of the individual and the context in which they live, as well as utilize dialogue and the exchange of knowledge to build shared knowledge[6].

The practices used as health education strategies should function as experiences that generate comprehensive improvements in the population's health and form active, autonomous subjects in the habits that promote health for themselves and the community[7]. It is essential that health professionals, as key players in the prevention, promotion, and recovery from any health problem, understand the importance of dialogue and developing a horizontal discourse. This leads to the construction of independent and responsible practice. This enables individuals to create coherent and effective behaviors in their daily life routine[8].

Health education is an integral part of the role of all members of the primary healthcare team and is one of the strategic actions to address both the health needs that require a more complex approach and the flow of services within the care and assistance network[9].

This study aimed to understand the conceptions and practices of health education among professionals in the Family Health Strategy.

Methods

Type of study

Qualitative study, following the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ). The study was conducted in a small municipality in the northeast of Brazil, located in the microregion of Médio Curu, mesoregion of Norte Cearense, based on data from the Brazilian Institute of Geography and Statistics. It has an estimated population of 12,928 people[10]. The municipality has seven registered family health teams and a small hospital that provides secondary care.

Population

The participants in the study were selected for convenience, as they were those working in primary care in the municipality at the time of data collection, which lasted 45 days. The city had 55 health profes-

sionals eligible to take part in their studies, who had been working in primary care for at least four months. An invitation message was sent via WhatsApp with information about the research and the procedures for voluntary participation. In response, 27 professionals confirmed their interest in taking part in the study: seven nurses, two doctors, six nursing technicians and assistants, and 12 community health workers.

The exclusion criteria were family health strategy professionals who were on vacation or leave, or who refused to participate. The inclusion criteria required that the professional had been working in primary care in the municipality for at least four months.

Data collection

The interviews were conducted individually, audio-recorded, and took place by prior appointment with the principal researcher at a location agreed upon between the interviewer and the interviewee. Twenty-four interviews were conducted at the municipality's Health Department, and three interviews were conducted at primary healthcare units. A script was used to pose open-ended questions about the conception and practice of health education in the municipality's primary care, including: What is the conception of health education? How is this knowledge implemented in the unit? What are the challenges to health education activities taking place in the unit? And others. Data saturation was evidenced when, during the interviews, no new information was recorded on the issues addressed. From the twentieth interview onwards, the data began to stabilize, with thematic convergence and recurrence of categories, suggesting saturation. Saturation sampling is a method used in qualitative research reports across various areas of knowledge to determine the final size of a sample, thereby preventing the inclusion of new members[11]. The interviews lasted an average of forty minutes, were recorded using a cell phone, and did not include images or video calls; the researcher later transcribed them.

In addition to the interviews, other data were recorded in a field diary. The participants completed a form virtually using the Google Docs tool, which was sent to them individually via WhatsApp, detailing their sociodemographic characteristics. The data was collected from July to September 2022.

Data analysis

The participants' statements from the interviews were analyzed using the content analysis technique. The technique involves studying the material step by step, dividing it into units of analysis that are worked on one at a time. The procedure involved paraphrasing the textual material, in which the least relevant passages were omitted, and similar passages were condensed and reduced[12].

A similar analysis was carried out, which represents the structure of the relationships established between the statements, as well as highlighting specificities related to the modalities of a variable[13]. Participants then named the textual material during the interviews. The audio recordings were transcribed in full and grouped by analogies of similarity, in which cardinal categories from 1 to 27 were defined, naming the professionals accordingly. An example of this analogy is a quote from a professional who said that he understood health education by showing patients how to take care of themselves. This statement, along with others like it, was grouped to create the analytical category of Self-care.

Ethical aspects

The participants in this study were informed of the nature of the work and its objectives and signed the Informed Consent Form. Approved by the Research Ethics Committee under Opinion number 5,486,139/2022 and Certificate of Submission for Ethical Appraisal 57137622.1.0000.5054.

Results

The figures presented below were created according to the main categories covered in the interviews: the participants' understanding of health education; the implementation of health education in the context of primary care; the motivations and challenges faced by primary care professionals in implementing the Health Education component; and the health education topics covered in primary care units.

Participants' understanding of health education

The participants' understanding of health education is illustrated in Figure 1, which outlines the key elements that comprise it.

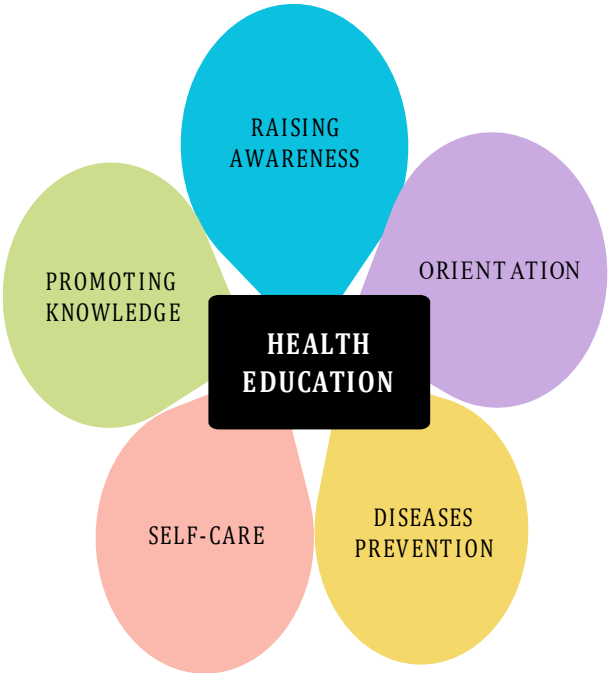

Figure 1 – Primary care professionals' understanding of health education in a small municipality in northeastern Brazil. Fortaleza, CE, Brazil, 2022

The following statements corroborate the evidence of these results: *It's promoting community knowledge* (Professional 1). *It's showing the patient how to take care of themselves. Do you understand? self-care, do you understand?* (Professional 2).

Implementation of health education in the context of primary care

The participants' health education practice is described in Figure 2, which shows the following elements:

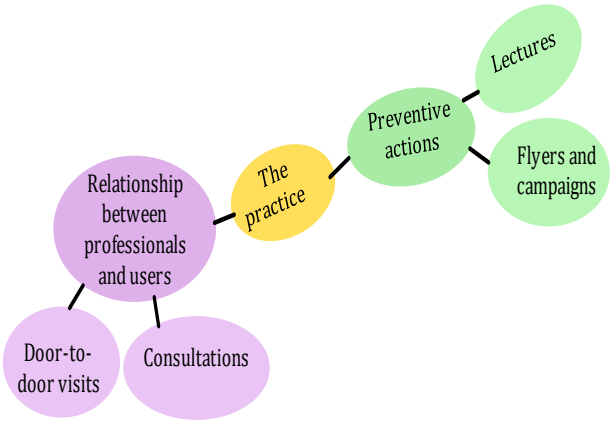

Figure 2 – Representation of the practice of health education in the context of primary care. Fortaleza, CE, Brazil, 2022

The following statements demonstrate these results: *It involves putting into practice certain attitudes towards health, which are practiced daily, and trying to implement health education in all my families, as well as in the preventive actions carried out at the UBS* [Basic Health Unit] (Professional 9). *I understand that it's house-to-house. On a day-to-day basis, we deal with the most common problems, don't we? That happens, depending on each region* (Professional 27). *We provide guidance with simpler information, trying to summarize the content and simplify it, because these are needy people, aren't they? They don't have as much access to information, so we attempt to simplify as much as possible and provide guidance whenever possible* (Professional 3). *We do it through guidance, don't we? And talks... during the Golden August, in October, we observe Pink October... and we also do it in schools, don't we? Additionally, during the service, we provide guidance* (Professional 12). *I do it in my classroom. We do it... Like Golden August and Pink October, but I try to do it in my room, individually, don't I? Where I'm most present with the patient* (Professional 13).

The motivations and challenges of primary health care professionals in implementing the Health Education component

Regarding the motivation for conducting the educational activity, participants commented on issues specific to their respective fields. One example was given, for instance, that the motivation to conduct educational activities stemmed from the fact that some areas are predominantly socially vulnerable. Others, however, prefer to address specific themes that, if worked on, can reach a wider audience, such as breastfeeding among pregnant women. It was also noted that health education actions can lead to an improvement in the quality of life for users. They provide guidance on prevention and help ensure that the population is not affected by pathologies that could be avoided.

The challenges of the educational action were represented in the speeches, which commented on the approach to the subject, as the topic needs to be approached differently depending on the audience. Another challenge was the population's resistance to participating in the health education activities offered by the team, as well as the occasional lack of time and resources. Figure 3 shows these motivations and challenges.

Figure 3 – Motivations and challenges of primary care professionals. Fortaleza, CE, Brazil, 2022

The following statements corroborate these results: *Social vulnerability is an area I could work on more, as my professional focus is more social* (Professional 1). *It's seeing the quality of life of many of my patients. When I find elderly people who are very idle at home, we end up motivating them to participate in a group of elderly people, to go out, to visit the health unit, and to meet other elderly people* (Professional 9). *It's good for us to make our patients feel good. Sometimes it's not even that they're ill; sometimes it's just that someone is there to support them, to give them the strength they need* (Professional 19). *There has to be collective work. Some of us find it easier to discuss the subject, provide examples, and... I use the illnesses we have* (Professional 1). *It's the family's own blockage. Because they occasionally become complacent, they feel the need to engage in physical activity, go out, talk, listen to a lecture, or listen to music, but they end up becoming complacent again. The challenge is to bring these people into a social environment. Every day we practice and keep hitting the same key. Eventually, the families give in and take part* (Professional 9). *I think the most significant challenge is that we have the time to carry out this health education. We try, don't we? Whenever possible, we utilize these campaigns, as I've already mentioned, the Golden August campaign, to attract more people and bring them in so that we can teach them about it* (Professional 3). *I view it as a challenge, and I must overcome it every day. There are times when we're more fragile, and there are times when we step back, but we continue to set goals and strategies to accomplish our objectives. Especially, I'll repeat it: being with the whole team, the team from*

the unit, and the PSF [Family Health Program], is significant because we share problems, try to solve them as a team, and work together (Professional 26). *The difficulty is sometimes the limited space at the clinic. And occasionally, we invite people; if it's in the morning, some find it difficult, while others don't. Talking to people sometimes improves it. Encouraging them with a joke, they feel more at ease, don't they?* (Professional 14). *I think it's working together, because when the issue is only addressed by one person, it doesn't seem to be a genuine concern; it appears that someone else has highlighted it as necessary. However, when a group of people work together, including those from the unit and other departments, then yes* (Professional 1).

Health education topics covered in primary health care units

The topics most addressed by the participants were women's health, child and adolescent health, maternal and childcare, leprosy, tuberculosis, hypertension, diabetes, public health, mental health, nutrition, physical activity, vaccination, arboviruses, and self-medication, as well as campaigns such as Pink October, Blue November, Golden August, and Yellow September.

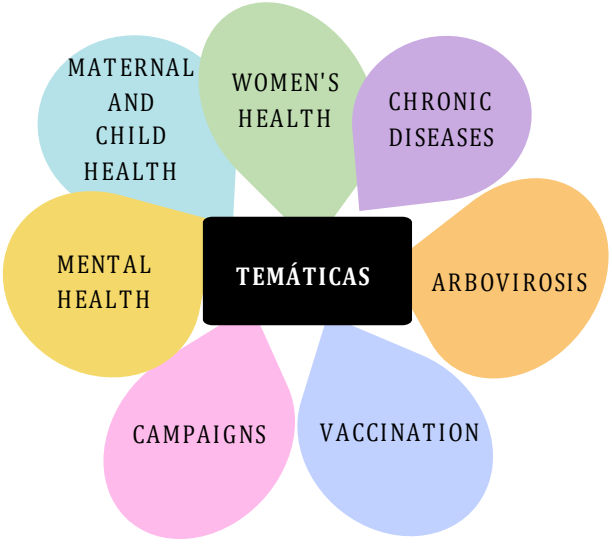

Figure 4 – Topics most addressed by participants in educational activities. Fortaleza, CE, Brazil, 2022

The following statements demonstrate these results: *Generally, we decide on a topic according to what is happening, or when the health department brings a topic to our attention, we work on it* (Professional 6). *Because they are relevant topics, and due to the number of cases. We combine the content, the lecture, and our practice* (Professional 5). *They're the topics we deal with most in the community, aren't they? They're the ones we deal with every day* (Professional 11). *Because many need it, we explain everything, and then with more men, they become more comfortable; when there are more, they start asking questions* (Professional 14).

Health education: user participation and changes in behavior

This study asked how users participate in health education activities and what changes the practice of health education is expected to bring about in users. There was little or no participation in terms of more interactivity.

The following statements portray the population's participation: *Some users are always present, but the vast majority, either due to difficulties or because they genuinely don't want to, try to avoid taking part* (Professional 28). *At first, it's just a lot of listening, right? They don't interact much; they don't talk. The vast majority listen, but we don't get any feedback* (Professional 26). *It's very participatory; they like it. It's very participatory in my area. When this user creates a bond with both the team and the health agent, everything becomes easier; we gain their trust and dialogue, and they feel more at ease* (Professional 9). *Some are very participative and ask questions, right? Some talk, not all of them, but some are sometimes more interested in the subject, who ask, and sometimes the others even want to know, but they're too embarrassed to ask, so they think it's good when others ask, so they know too*" (Professional 16). *Occasionally, they come across a question on the internet and seek our verification to confirm its accuracy, don't they?* (Professional 3).

Regarding the expected changes that the practice of health education causes in users, it was clear that the activities raise awareness, provide guidance, and foster the bond that is generated between professionals and users: *Leading to an increased interest in improving and a genuine desire to seek help. The health agent said, "You must go* (Professional 1). *I think that people take a lot of what they hear home with them and implement some guidelines at home* (Professional 8). *After we've done it, don't we? We always see the comments afterward,*

and so they get more... they always remember what happened and everything (Professional 16). *The process of understanding the health-disease relationship is fundamental for the prevention of new problems, the treatment of existing diseases, and for interpersonal awareness within the community, isn't it?* (Professional 24). *Absolutely, because occasionally it's not everyone, but some individuals lack experience and knowledge, and then we see that it improves* (Professional 14). *A very positive effect. When it takes me a while to get to that residence in my area, then I go back. Where am I? Remembering that meeting we always had this month? Isn't there going to be one this year?' We end up creating this bond with the user, and they charge us, don't they?* (Professional 9). *I realize that after this health education work, we will have more access to them, which will automatically make it easier. They start to trust us more, come to the unit more frequently, and attend their routine appointments and exams* (Professional 26).

Discussion

The results of this study revealed various aspects of understanding health education, its relationship with practice, and the changes expected from users[14]. Health education raises awareness at both individual and collective levels about what each person can do to improve their living conditions, fostering confidence and greater control over their health and that of the community[15]. By conducting health education that prioritizes enhancing communication and interaction with the population, professionals can transform the lives of users, making them aware of aspects that promote their health[16].

Educational practices in the primary care work setting play a crucial role for both professionals and users, as the quality of care prioritizes actions to prevent, promote, and recover health, encompassing the entirety of care[17]. There is a need for educational strategies implemented by professionals to enhance users' ability to maintain self-care, adapting this practice to their daily lives, thereby improving the quality of life for these individuals[18].

Health education is characterized as an instrument of construction and dialogue, a builder of knowledge that stimulates autonomy, people's participation in health actions, and the protagonism of individuals in their own care, which can lead to progress in the community's well-being[19].

According to the relationships established between professionals and users, educational practices influence their ways of thinking and acting. The process of health promotion is also a teaching and learning process, as both the health professional and the user participate in it as active subjects, engaging in a mutual teaching and learning process. Users also participate in the process of building a more stable health for all[20].

Regarding social vulnerability, the literature emphasizes the importance of maintaining care and education to mitigate it, thereby providing a healthy territorial environment and reducing the population's levels of illness[15]. The population's lack of information poses a serious risk to public health, as it compromises people's behavior and exposes them to risks[21].

It is essential to emphasize the importance of comprehensive care, with a general view of the territory, understanding the values of the population and their health needs, stimulating promotion and prevention strategies, and making all these aspects essential in the work of the health teams that carry out their activities in these territories[22]. Educational activities can take place during consultations and appointments, as well as in collective settings with patients and conversation circles[7].

Health teams often face the challenge of promoting co-responsibility among users in the comprehensive approach to care. The collective construction of knowledge between professionals and the population can make a significant contribution to promoting health and improving care for the population[23].

Certain professionals encounter obstacles that make it difficult to carry out health education, one of which is user resistance to participation. This situation is justified by the lack of interest shown by the population and the limited time available[24].

Social participation in services is viewed as an

enhancement of health in people's daily lives, highlighting the population approach as a strategy in primary care work[25]. Professionals encourage users to participate more actively in educational activities, so that they are involved in the collective search for improvements in care[16].

Regarding teamwork, the interaction between professionals can generate tools that aid in health education actions and strengthen the team, reflecting the integration and effectiveness of the strategies developed[26]. It is essential for professionals to effectively carry out integrative work, recognizing that knowledge needs to be generated in a reciprocal manner. They need to have the autonomy to transmit knowledge that improves the user's health condition technically[27].

Caring for individuals is not the exclusive function of a single professional, and the approach to caring for users must be integrated with the health team, in all its comprehensiveness and complexity. Therefore, the development of skills to carry out the process of caring for the population must be outlined, as it affects both individuals and the healthcare teams in that area[23].

The proposals mentioned in an educational action, such as the level of education of the users, the language, and the materials used, promote people's participation and provide involvement in the construction of shared knowledge. In addition, professionals value the participation of the population and encourage active involvement, thereby fostering a shared interest among those involved[16].

It is through health education that bonds can be forged, leading to increased trust between health teams and the community. The involvement of professionals in health education activities, combined with their ability to generate effective communication, is crucial in creating bonds that can lead to potential changes in users' lifestyles[28].

Professionals play a crucial role in transmitting knowledge and expertise, guiding the region on improving health conditions, fostering self-confidence, sharing experiences, and delivering comprehensive care through technical and scientific teachings[29]. The complexity present in a territory necessitates a systemic understanding of care, given the cases presented by a population. The importance of an effective connection between the subject, the context in which they live, and the health professionals is also considered[30].

Study limitations

During the research, some obstacles were encountered, including delays in returning the online forms, which required the primary researcher to contact them via *WhatsApp* to ensure that the answers were received in time for the schedule. Some professionals refused to participate in the interviews after signing the informed consent form, which the leading researcher approved in accordance with the research's ethical principles. The schedule adjustments for the interviews with participants had to be modified due to their work schedules, but this did not cause any damage; instead, it resulted in a delay in the execution of the research timetable. However, the expected results were obtained from the study participants, which did not compromise the quality of the data; instead, it impacted the research timetable. The selection of participants based on the convenience of working in the municipality was not characterized as a risk of not capturing a diverse range of experiences, as different professional categories participated with varying lengths of experience in their professions. The lack of data triangulation and reflexivity can be considered methodological limitations.

Contributions to practice

Following the research, a technical note was prepared for the participants and the municipality's managers, containing recommendations for enhancing health education initiatives in primary care. In this note, it was pointed out that health education is developed in various ways by many professionals,

either through specific actions or as part of the daily routine of the health unit; however, it is still necessary to implement and encourage the further development of this health education activity in Primary Care within the municipality.

The following proposals were suggested: to recognize the perceptions and interests of the target audience; to adopt conversation circles in the communities for greater interaction and the creation of bonds between users and professionals; to adopt the use of social networks for the dissemination of content by the Family Health Teams, given that the internet is an essential communication tool; and to carry out permanent health education activities frequently for the professionals, to encourage training to insert health education more regularly, followed by an evaluation of this health practice.

Conclusion

Most of the answers related to the concept of education focused on promoting knowledge, raising awareness, and educating the population through health promotion, guidance, disease prevention, and access to health resources. They also encouraged participation in programs offered by the Family Health Strategy.

Regarding the practice of health education, it was revealed that it was employed in various ways, including house-to-house visits, lectures held at the unit, group talks, and providing guidance and information during care. It also encouraged participation in campaigns promoted by the teams.

Authors' contributions

Conception and design or analysis and interpretation of data: Silva ACG. Writing of the manuscript or relevant critical review of the intellectual content; Final approval of the version to be published; and Agreement to be responsible for all aspects of the manuscript relating to accuracy or completeness being investigated and resolved appropriately: Silva ACG, Rebouças LN, Silva MRF, Gubert FA, Vieira NFC.

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