

KNOWING THE REASONS FOR NONADHERENCE TO HEALTH EDUCATION ACTIONS
CONHECENDO OS MOTIVOS DA NÃO ADESÃO ÀS AÇÕES EDUCATIVAS EM SAÚDE
CONOCIENDO LOS MOTIVOS DE LA NO ADHESIÓN A LAS ACCIONES EDUCATIVAS EN SALUD

Maria José Sanches Marin ¹
Maria Yvette Aguiar Dutra Moracvick ²
Luciane Cristine Ribeiro Rodrigues ³
Simone de Carvalho Santos ⁴
Flávio Henrique da Silva Santana ⁵
Débora Meira Ramos Amorin ⁶

¹ Doctorate in nursing, Faculty in the Nursing Program of the School of Medicine of Marília. Marília, SP – Brazil.

² Medical dermatologist, Faculty in the Medical Program of the School of Medicine of Marília. Marília, SP – Brazil.

³ Doctorate in Public Health of the UNESP of Botucatu, Nurse in the Family Health Strategy of the City of Marília. Marília, SP – Brazil.

⁴ Specialist in Family Health, Nurse in the Family Health Strategy of the City of Marília. Marília, SP – Brazil.

⁵ Academic, Nursing Program of the Nursing Program of the School of Medicine of Marília. Marília, SP – Brazil.

⁶ Academic, Medical Program of the School of Medicine of Marília. Marília, SP – Brazil.

Corresponding Author: Maria José Sanches Marin. E-mail: marnadia@terra.com.br

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ABSTRACT

This research presents a breakdown of activities performed by a group of students, tutors and preceptors as a proposal of the PET-Health Project of Marília College of Medicine in partnership with Municipal Health Secretary of Marília. Having proposed to analyze the reasons for nonadherence to a community's educational actions nine interviews were conducted with users who, having been invited to participate in education actions within a group, did not attend. Data analysis allowed the development of three units of meaning, which revealed the difficulty of exercising citizenship and the incompatibility with wishes and possibilities of the community; disinterest of the population and the emphasis on the biomedical model permeating healthcare actions, and indications for developing such actions. Facing the challenges to be confronted when glimpsing changes in the care model, it is believed that there is a necessity to review the process of team work and to recognize that changes happen in a slow and gradual way.

Keywords: Health Education; Patient Compliance; Health Promotion.

RESUMO

O presente estudo apresenta um desdobramento das atividades realizadas por um grupo de estudantes, tutores e preceptores, que compõe uma proposta do Projeto PET-Saúde da Faculdade de Medicina de Marília em parceria com a Secretaria Municipal de Saúde de Marília. Tendo como proposta analisar os motivos da não adesão de uma comunidade às ações educativas, foram realizadas nove entrevistas com usuários que, convidados para ações educativas em grupo, não compareceram. As entrevistas foram gravadas e transcritas. A análise dos dados possibilitou a elaboração de três núcleos de sentido, os quais revelaram a dificuldade em exercer a cidadania e incompatibilidade com os desejos e possibilidades da comunidade; o desinteresse da população e a ênfase no modelo biomédico permeando as ações de saúde e indicações para desenvolver tais ações. Frente aos desafios a serem enfrentados ao se vislumbrarem mudanças no modelo de atenção, acredita-se na necessidade de rever o processo de trabalho da equipe e reconhecer que as mudanças acontecem de forma lenta e gradual.

Palavras-chave: Educação em Saúde; Cooperação do Paciente; Promoção da Saúde.

RESUMEN

Este estudio presenta el desglose de actividades de un grupo de estudiantes, tutores y preceptores que forman parte de una propuesta del Proyecto PET-Salud de la Facultad de Medicina de Marília juntamente con la Secretaría Municipal de Salud de dicha ciudad. Con la propuesta de analizar los motivos de la no adhesión de una comunidad a las acciones educativas, fueron realizadas nueve entrevistas con usuarios que no se presentaron a las acciones educativas en grupo. Las entrevistas fueron grabadas y transcritas. El análisis de datos permitió elaborar tres núcleos de sentido: dificultad en ejercer la ciudadanía e incompatibilidad con los deseos y posibilidades de la comunidad; desinterés de la población y énfasis en el modelo biomédico que impregna las acciones de salud y, finalmente, indicaciones para desarrollar tales acciones. Ante el reto de los cambios en el modelo de atención, es importante considerar la necesidad de rever el proceso de trabajo del equipo y reconocer que los cambios suceden de forma lenta y gradual.

Palabras clave: Educación em Salud; Cooperación del Paciente; Promoción de La Salud.

INTRODUCTION

The current National Health Policy establishes principles distinct and guidelines of the model of care that has perpetuated for many years in our reality, which is centered on the biological aspects, in the cure of disease, in the hospital as a primary setting of health care and the protagonism of the medical professional. This model, in addition to not meeting the health needs of the population, demands a significant financial investment for its sustainability.

In the newly proposed health care, defined as objectives and attributions of assistance to people by means of actions of promotion, protection and recovery of health, with the integrated realization of health care assistance and preventive activities, within the logic of health surveillance.¹

In this perspective, found in growing the deployment process throughout the national territory, the Family Health Strategy (FHS) constitutes the principal guideline for the reformulation of health practices. Structurally composed of a team of professionals, it is expected that this team will be capable of continuous and comprehensive care to families in the enrolled area, for the identification of situations of health risk in the community and assisted coping, in partnership with the community, with the determinants of the health – disease process, with views to the development of educational processes aimed at improving self-care of individuals.²

Teamwork in health care units should encourage family involvement and community participation in the construction of a common project of health care, since the reference population is the recipient of the work developed, assuming a process of democratization of the institutions.

The philosophy of the FHS seeks, therefore, to achieve long-term change in the relationship between the citizen and the state, promoting the concept of health as a right of citizenship and enabling active participation of the individuals in the processes of improving quality of life, by means of their participation in the public policy discussion.³

New commitments and responsibilities are expected, therefore, on the part of healthcare professionals, managers and the community, which demand new attitudes and ways of acting and thinking in the face of the health needs and their respective healthcare.

To this end, the Ministry of Health (MOH) has made available resources for the structural organization of the teams, facilitating access by the population to the services, as well as making investments in the training and accreditation for professionals in order to develop a modality of care that promotes improved quality of life of people.

To move in this direction, the educational actions emerge as an essential tool, as it encourages self-esteem and self-care, by means of reflections that lead to changes in attitudes and

behavior, to increase the participation of the subjects and the collectivity in the modification of the process determinants health-of health-illness.⁴

Thus, the concept of health is understood in a broad way, including public policies, appropriate environments, and reorientation of health services beyond clinical treatments and dressings.⁵

Although there is an understanding of the necessity to improve the living conditions of the population by means of health education, in everyday services, great difficulty in population adherence to these educational actions was observed, which caused disappointment and misunderstanding of the fact by professionals in the team, reducing the possibilities of encounters between the actors necessary for the healthcare process.

This verification was also evident for students, tutors and preceptors of the proposed “Health Care: recognizing the perceptions of a population”, developed at the Family Health Unit (FHU), Vila Barros, Marília, supported by the Education Program for the Work for health (EPW HEALTH), Faculty of Medicine a Marília (FAMEMA) in partnership with the Municipal Secretary of Health (MSH) of Marília.

In this proposal, which had as objectives to recognize the perception that this population has concerning health, and to devise a plan of participative action for implementation, together with the community, five workshops for workers were held, using different strategies as motivation for discussions: use of images, movies, educational games, word cards and the construction of posters.

As a prerequisite for conducting these meetings, invitations were prepared by the students themselves or delivered by community health workers. For each workshop about 50 people were invited, with an average of 15 being in attendance. Many of these were not invited in advance, but were people passing by or who lived near. This aspect caused concern among organizers. What are the reasons for nonadherence to such actions in this population?

Adherence, from an etymological point of view, from the Latin *adhaesione*, means junction, union, approval, consent, expression of solidarity, support; it presupposes relationship and linkage. It is understood to be a multifactorial process, structured by the relationship between caregiver and whoever is receiving care, and involves constancy, perseverance and frequency.⁶

In that perspective, referring to the factors related to adherence, the link between professional and patient is a structural factor and one of consolidation of the process, because it involves aspects linked to recognition and the acceptance of their health conditions and the development of consciousness for self-care. It is considered that, if dealing with a process that suffers different influences, to facilitate adherence and to adhere to healthcare actions are tasks that demand sustained attention.⁶

In the literature, the majority of the studies dealing with adherence refer to the process of illness and medication treatment, making it difficult to improve understanding of the conditions that can be involved in the adherence to educational actions, but these demand the construction of a civic conscience.⁷

Considering the importance of the development of educational actions to confront the necessity of change in the model of healthcare and the difficulties of the team in obtaining adherence of the community, a study was proposed to analyze the reasons for nonadherence to these actions.

METHODOLOGY

This was a qualitative study working with values, beliefs, habits, attitudes, representations and opinions, with the proposal of deepening the complexity of facts and particular processes and specifics to individuals and groups. A qualitative approach was employed, therefore, for the understanding of phenomena characterized by a high degree of internal complexity.⁸

The present study was conducted in the catchment area of the unit FHS Vila Barros, whose population, according to data from MSH, is 921 families, totaling 3,189 people. This unit has a multidisciplinary team minimal, as proposed by MS.

The FHS Vila Barros is inserted in the peripheral region north of the city of Marília, SP, in the Vila Barros neighborhood, which corresponds to the most recently occupied region of the city. The site had a more intense and disorganized population increase in recent years, is predominantly residential, with few commercial establishments, no industry, schools, daycare centers, clubs or sports centers. There are Catholic and Evangelical churches.

With the aim of understanding the reasons for nonadherence, nine users who had received the invitation to participate in the workshops on "hygiene care", and who did not attend the activity, were interviewed. The criteria for sample selection were those that direct qualitative studies, namely, we considered the number of subjects in sufficient quantity when the survey questions were discussed in depth, with the possibility of successive inclusion of subjects, if necessary. In that perspective, the empirical picture terminated when saturation was observed of the meanings in the responses of the interviewees.⁸

For data collection, interviews were conducted in the residences of the participants, following a previously established routine, which included questions regarding the meaning of the invitation, the reason for non-participation and suggestions for accomplishment of educative activities by the health unit. The interviews were recorded on a digital recorder, with subsequent transcription in full.

The study had the authorization of the Secretary of Health of the city and approval of the Ethics Committee in Human Re-

search at Famema. Those who agreed to participate signed the terms of free and informed consent.

For reference and to guide data analysis, we opted for the dialectical hermeneutics, with reference to the principles of the method of interpretation of meanings, which turn to the interpretation of the context, reasons and logic of statements, actions, correlating data to the set of interrelationships and situations, among other analytical indicators. One works with broadest meanings, in a movement of synthesis by the construction of possible meanings.⁹

From this perspective, the work of analysis begins with the comprehensive reading of the material obtained in interviews, followed by the approximation of ideas, characterizing them into units of meaning and ending with the interpretation of these, what constitutes a moment of synthesis.^{8,9}

RESULTS AND ANALYSIS

The data analysis allowed the development of three units of meaning, that revealed the difficulty in exercising citizenship and incompatibility with the wishes and possibilities of the community; disinterest of the population and the emphasis on the biomedical model permeated the healthcare actions; as well as indications for such actions to be developed.

Difficulties in exercising citizenship and the development of actions incompatible with the wishes and possibilities of the community are exemplified in the statements below:

I think that the administration of them there that have to see if not all right[...] how can I say, you have to do that, so I do not make a suggestion (E8, fem., 38 years, housewife).

Look, I got crazy the way they explained, then the day came[...] only at that time appeared housecleaning work and, you know, people who live with temporary work [...] (E1, fem., 33 years, cleaning woman).

The group of bread interested me, others I did not even attend (E2, fem., 35 years, unemployed).

Although social participation is considered a prerogative of the SUS, the study about the Family Health Program (FHP) reveals the absence of the user as the protagonist of his own life and the production of his care, since the team still puts the population outside the scope of the decisions about what to concerns him.¹⁰ Advancements in the participation and the teamwork have not guaranteed the construction of a common healthcare project.¹¹

Democratic participation in the decisions and actions that define the fate of Brazilian society has been hard won, having seen the authoritarian and exclusive tradition that has constituted Brazilian society throughout history.¹²

The fact that that citizenship “is not natural” is called to attention, since it is subject to social and cultural rules. In collectivist societies, such as this in which we live, “the whole prevails over the parts, the hierarchy is the basic principle and what is valued is the relationship.” Thus, if the individual does not have any connection with people or an institution of prestige, he is treated as inferior.⁷

From the foregoing, it was considered that the effectiveness of the actions of health education depended on the construction of links between people and health professionals, with a view to establishing goals that led to changes in behavior in health promotion and well-being.¹³

As a pattern based on the statements of the subjects, there was also the existence of “disinterest of the population and emphasis on the biomedical model, permeating health actions” conforming to:

[...] these groups that they have there are for high blood pressure and I do not have high blood pressure nor diabetes (E5, masc., 53 years, auxiliary mason).

[...]because everything that passes is for us to see, I already have experience within that, about the pressure, sometimes about cancer, so people already know [...] (E6, fem., 27 years, street vendor).

We here only are seen as a patient and we see them as physician (E1, fem., 33 years, cleaning woman).

I have not thought so, I have not given it importance [...] (E3, fem., 54 years, housewife).

In the current scenario regarding health care, even if there is a clear definition and understanding of the necessity for changes, the valuation of the cure, medication use and the biological aspect as the only way to obtain improvement in health conditions is still present in the imagination of both users and the team. This can hinder the adherence and, consequently, the delineation of a set of measures aimed at promotion and prevention, in order to attend to the the needs of people.

It is emphasized, also, that the cases of resistance revealed, many times, that people felt devalued or were not having a real dialogue between the knowledge from the team and the users. Also noteworthy was that, in the confrontation of knowledge, it was important to consider the complexity articulated in the nucleus of the explicit histories and culture, obtaining, therefore, the understanding of difficulty for adherence.¹⁴

It seems, therefore, that the lack of adherence of the population of the measures of health care in the search for improving the quality of life demand strategies that involve creativity and recognition of its needs.

However, in the critical analysis of the literature about adherence/nonadherence to the treatment of people with chronic diseases, the conception of the role of the patients in the

process of adhering to treatment was found reduced, since professionals considered them submissive to health care, limiting, thereby, their possibility of active participation.¹⁵

The users interviewed indicated possibilities for obtaining more community adherence to educational activities, which involved more disclosure, improved communication, increased number of meetings and diversification of the subjects discussed, according to the following reports:

I think so, I had to meet more[...] there everything is gathered, the community, and we can help and do things better because I have already seen in other neighborhoods the post together with the community[...] (E1, fem., 33 years, cleaning woman).

More disclosure. A lot of the time the staff does not know[...] (E7, masc., 63, retired).

They are missing more communication between clinic staff and the people here who are the patients. (E4, fem., 23 years, housewife).

I think it is better to call people from outside to better explain[...] because it is always the same thing, do not eat it because it harms[...] (E9, masc., 49 years, collector of recyclable material).

Although the community has shown disinterest, to the impossibility and valuing of aspects related to curative care as conditions that prevent participation in educational activities, the participants expressed in their statements that more incentives, better communication, and diversification of offers of activities that allow social interaction and health promotion are needed.

It stands out, in the last word, that, to suggest “people from outside” to perform the educational activities, these are developed in an authoritarian way, discursive and repetitive, without considering the individuality of the subjects and the complexity in which they are involved.

In this respect, it also rescued the considerations that, at present, the educational practices within healthcare should not lend themselves to control and to the discipline of people, but to the construction of active subjects for self-management and self-care of health.¹⁶

FINAL CONSIDERATIONS

Upon arriving at the final considerations of the study, we had to recognize that, although the statements of users revealed important aspects of the decisions facing the proposed development of health education actions, it was necessary that they also identify the team’s vision, considering that this may be dressed with prejudices that need to be unveiled when facing the numerous factors involving adherence to health care.

Furthermore, it is important to note that the study was conducted in a single FHU, which presented specific characteristics, although it is possible that other communities face similar problems.

When analyzing the words of users who were invited and who did not adhere to educational activities, numerous challenges faced when they envisioned changes in the model of attention were found, since they constitute the main form of empowerment of the subjects, preparing for the exercise of self-care and autonomy. Educational practices for the present, therefore, should articulate the uniqueness and the complexity that involve the people and the community.

The adherence difficulties of the interviewees revealed the necessary confrontations, and, first it is necessary to review the work process and recognize that changes are slow, gradual and with possibilities of advances and setbacks.

In the perspective of changes in the health care model, it can be stated that the PET-Health constitutes a powerful initiative, since it favors the formation and training of professionals guided by new concepts and practices that lead to increased understanding of the concept of health- illness, as well as the recognition of the complexity in which the process of health care is inserted.

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