

HEALTH EDUCATION PRACTICE AS PERCEIVED BY SENIOR HIGH STUDENTS

Cícero Tavares Leite¹, Roberta Peixoto Vieira², Caroline Antero Machado³, Glauberto da Silva Quirino⁴,
Maria de Fátima Antero Sousa Machado⁵

ABSTRACT: This quantitative study was undertaken with 571 students aged between 14 and 19 years old from three state senior high schools, aiming to describe the students' perceptions regarding the practice of health education in the school. Data collection occurred following the acceptance of the adolescents and those legally responsible for them, between February and March 2012, through questionnaires with objective questions, organized using the Statistical Package for Social Sciences software, version 18.0, with data presented through description, frequency and in tables. The results indicated that (59%) recognized the existence of times of health education, addressing sexuality (61.5%), and alcohol and drugs (59.6%). According to those studied, (43%) asserted that there had been no qualified listening prior to the activities, (66%) did not recognize the participation of the Family Health Strategy, and 56% evaluated the pedagogical interventions as dissatisfactory. It is concluded that the Family Health Strategy must work alongside the adolescents so as to strengthen the bonds with this public.

DESCRIPTORS: Adolescent; Health education; Education, primary and secondary; Health promotion.

¹Student of Nursing. Regional University of Cariri. Fellow of the National Council for Scientific and Technological Development (CNPq). Barbalha-CE-Brazil

²RN. Specialist in Family Health. Professor at the Regional University of Cariri. Barbalha-CE-Brazil

³Dentist. M.A in Collective Health. Professor at the Maurício de Nassau Faculty. Fortaleza-CE-Brazil

⁴RN. Ph.D in Education in Sciences: Chemistry of Life and Health. Professor at the Regional University of Cariri. Barbalha-CE-Brazil

⁵RN. Ph.D in Nursing. Professor at the Regional University of Cariri and at the School of Public Health, Ceará. Fortaleza-CE-Brazil

Corresponding author:

Cícero Tavares Leite
Universidade Regional do Cariri
Rua Aderson Sabino, 225 - 63180000 - Barbalha-CE-Brasil
E-mail: ctavaresleite@bol.com.br

Received: 03/07/2013

Approved: 19/12/2013

INTRODUCTION

Adolescence is one of the surprising stages of human life, and is characterized by intense biopsychosocial changes, perceived and experienced differently, with distinct interpretations and treatment depending on the culture in which the individual is integrated⁽¹⁾. The field of study on adolescence has gained attention in recent decades as a result of the increase of this population and because of questions which involve it and cause concern, such as unplanned pregnancy, sexually transmitted diseases (STD/aids), violent deaths from firearms, violence in traffic, and the use of licit and illicit drugs⁽²⁾.

In view of the vulnerabilities to which this population may be exposed, the need arose to implant public policies which considered adolescent health not just from a biomedical-curative prospective, but comprehensively. As a result, the Family Health Strategy (FHS) has to meet this broadened prerogative of care. This Strategy represents an advance for health promotion for this public; however, it does not yet present programmed or systematized actions for attending adolescents⁽³⁾. From this perspective, there is an urgent need to develop intersectorial actions and for the school to come to be considered a locus of care in the context of health promotion.

In a broad sense, health promotion refers to the conquest of the technical power (ability) and political awareness of the communities (empowerment) in order for individuals and the community to resolve problems, in the search to create environments which are favorable for health and which allow equality of opportunity such that all may fully realize their health potential⁽⁴⁾. In this philosophy, the educational actions in health must be planned and directed at the appropriate target-public, articulated by the multi-professional team, and undertaken continuously, given that the subjects need and desire to know so as to promote their health.

This being so, the process of health education uses an essential tool in its work scope, communication, which must consist of feedback capable of promoting the construction of knowledge and skills so that the adolescent public may make choices based on a critical awareness, based in measures which alter the status quo and lead the actors to participate in the process⁽⁵⁾.

Health education, as a process, a way of thinking, a liberating pedagogic doing, that is, in the possibility of the development of the subjects' individual or collective intellectual autonomy, involves becoming closer to the adolescent, given that the specific characters of

each group must be considered, as well as the social surroundings in which they are inserted. As a result, this study's proposal was based on research undertaken in the city of Barbalha in the Brazilian State of Ceará with school students. The study showed that they recognize the FHS not as a space which promotes health but only as for resolving problems centered on disease, as there are no times directed at this public in the primary healthcare centers focusing on health education as an emancipatory tool for health promotion⁽⁶⁾.

Considering these observations, we were concerned about another aspect which can also influence health and education for the adolescent; the school, as this must act as a participant in the shaping of the subjects who are imbued in the process of citizenship and learning in health. Therefore, in addition to being current, working on the issue proposed here is fundamental for shaping citizen-youths and, in this regard, the nurse is an essential agent in the didactic-pedagogic process in transformative health.

From the above, the study object was outlined based on the following guiding questions: Do the schools promote times directed towards health education for adolescents? What issues are worked on? Are the adolescents consulted beforehand? What is the participation of the FHS? What technologies are used? From this point of view, this study aimed to describe the perceptions of the adolescent students regarding the practice of health education in school.

METHOD

This is quantitative research, undertaken in three state senior high schools, belonging to the state network in Barbalha in the state of Ceará, Brazil. The city has three state senior high schools, located in the open zone, registered under the 19th Regional Management for the Development of Education (RMDE 19). The choice of this research setting was made because the schools are part of a project in partnership with RMDE 19, termed "Teacher as Group Leader" which aimed to work in conjunction with the students on issues about sexuality, sexually transmitted diseases (STD), prevention of drug use and the bringing of the school closer to the community.

Each school had, respectively, 958, 774 and 360 students, totalling 2118 students enrolled. For the calculation of the sample size, random sampling by conglomerate was used, which must be used when the population is subdivided in small groups or conglomerates⁽⁷⁾. The

selection of the sample was proportionate to the number of students in each school, corresponding respectively to 212, 199, and 160 students, making a total sample of 571.

Data collection occurred in February and March 2012, through the use of questionnaires with objective questions. The variables investigated were: age, sex, marital status, the existence of times of health education in the school, the insertion of the FHS in the school, which professional led the activities, which materials were used, and the adolescents' evaluation of the educational episodes.

Following authorization from the management of each one of the schools, the teachers provided an opportunity during the lessons so that the researcher could explain the objective of the research, the Terms of Free and Informed Consent, and the Post-clarification Terms of Consent, along with the questionnaires to be taken home by the adolescents. The authorization of the parents or guardians was requested through signing the Post-clarification Terms of Consent, in the case of those under 18 years old.

On that occasion, 318, 299 and 240 questionnaires respectively were distributed in the schools, that is, 50% more in relation to the sample calculated, bearing in mind the possible losses due to students not attending, or for other reasons. The period of one week was established for collecting in the same. As a result, it was necessary to return to the schools on three consecutive occasions until the sample was completed. The criteria for inclusion in the study were: to be adolescent (10 to 19 years old) and to hand in the questionnaire during the data collection period.

In order to validate the collection instrument, a pilot test was administered in another school which had similar characteristics to those in the study, resulting in the adjustment of the questionnaire. The data was organized using the Statistical Package for the Social Sciences software, version 18.0, and the results were presented in terms of description and frequency, and in tables, followed by the analysis and discussion of the data with the support of the literature, focusing on the issues of the adolescent and health education. The study was undertaken in line with Resolution 196/96⁽⁸⁾; to this end, it obtained a favorable decision from the Research Ethics Committee of the Regional University of Cariri, under Protocol n. 98/2011.

RESULTS

This study's sample was made up of 571 students distributed in three schools, termed schools A, B and C, involving, respectively, 212, 199, and 160 adolescents.

Regarding sex, 217(38%) were male and 354(62%) were female. The study participants' mean age was 16.59(\pm 1.27), varying from 14 to 19 years of age. Regarding marital status, 553(97.5%) stated that they were single, 14(2.5%) that they were married or in a stable relationship, and 4(0.7%) did not answer.

When asked about the existence of occasions directed at issues of health education in the school, 337 (59%) stated that such occasions existed, 231(40.5%) did not recognize these occasions and 3(0.5%) did not answer. It was ascertained that at these times the school addressed issues related mainly to sexuality and alcohol/drug use.

According to the adolescents researched, the issues addressed in the schools were: sexuality 392 (61.5%); alcohol and drugs, 340(59.6%); contraception, 164 (28.8%); oral health, 61(10.7%); and eating disorders, 15(2.3%). The sum was greater than 100%, bearing in mind that they could indicate more than one option, as happened with other variables present in the study. All the issues indicated by the adolescents were present in the instrument administered.

According to the adolescents researched regarding the choice of the issues addressed in the health education activities, 245(43%) mentioned that the health or education professionals did not consult them to investigate their opinions and needs; 143(25.1%) asserted that the professionals asked the students directly regarding what they wished to be addressed; 136(23.9%) indicated that the professionals had undertaken group-work for surveying these issues; and 104(18.2%) mentioned the use of suggestion boxes.

It was also ascertained that the issues worked upon were in line with the interests of the adolescents, who showed greatest interest in the following issues: sexuality, 344(60.4%); alcohol/drugs, 225 (39.5%); methods of contraception, 79(13.9%); and oral health, 61(10.7%).

Regarding the insertion of the FHS professionals in the school, one can observe their relative absence, given that most of the adolescents, 337 (66.8%), asserted that these had never visited the school (Table 1).

Table 1- Frequency of the Family Health Strategy professionals in the school. Barbalha-CE-Brasil, 2012

Variable		%
Never visited the school	377	66,0
Visited on a single occasion	108	19,0
Visits the school frequently	79	13,8
Did not answer	7	1,2
Total	571	100

Among the professionals who undertook educational actions in health for adolescents in the schools, the following were mentioned: teachers from the schools, 201(35.2%); nurses, 161(28.3%); Community Health Workers (CHW), 98(17.2%); dentists, 10(1.8%); doctors, 9(1.6%); 92(15.9%) did not answer.

For leading the health education sessions, the adolescents identified the use of videos, 368 (64.7%); posters, 173 (30.4%); and competitions, 41 (47.2%). In relation to the health education sessions, according to the perception of the adolescent students, 234 (41%) classified them as good; 320 (56%) as dissatisfactory and 17 (3.0%) did not answer.

DISCUSSION

The adolescents appear to be interested in obtaining more information on the issue of sexuality, although how the teachers addressed this in school, and the dimension with which it appeared in the study, were not an object of the investigation.

In this regard, the adolescents placed this issue as a priority and intrinsically indicated the school as a mediator for dealing with the issue. This suggests that they feel comfortable in that environment, perhaps because they are in a group and this in some way creates an opportunity for the work with this public for the teachers. However, this neither exempts the responsibility for dialog within the family, nor the responsibility of the FHS as a holder of co-responsibility for focussing on sex education for this clientele.

It is noted that there may be abstention or distancing by both the family and the FHS regarding taking on the role of sex education for the adolescent, and the school often meets difficulties regarding dealings with this subject, either through the teacher's lack of experience in socializing this issue due to the shortage of didactic-pedagogical resources, or because they believe that this role is not part of their job description⁽⁹⁾.

Health, school and family must unite in order for the adolescent public to overcome situations of vulnerability and reduce the gap between the actions directed at sex education and the need indicated by the actors who educate and care for this group. This is possible based on the displacement of the embarrassment related to gender and the stereotypes which strongly influence the values and attitudes of the people, for an inclusive, citizenship-based and emancipatory dimension which considers the historical, social, political and cultural aspects, besides the biological and moral materiality of sexuality.

This assertion is corroborated by another study which shows that the teachers did not address sexuality for the adolescent, apart from aspects which were directed at the biological sciences. And this approach was directed at biologicism and bodily hygiene, and was restricted to pedagogical content, with no concern in addressing other questions linked to sexuality⁽¹⁰⁾. It may be perceived that the issue of gender in sexuality is steadily becoming more recognized in various segments of society, through political discussions, in the media and in academia.

In relation to the second issue, alcohol and drugs, another study showed the early consumption of alcohol by adolescents starting at approximately 12 years of age; this intake is motivated mainly by curiosity, the influence of friends, and by ignorance of the harm caused by these substances in the body, the family and social group⁽¹¹⁾.

Besides public policies for harm prevention and protection of the child and adolescent, health education actions directed at this issue are fundamental. And the school, the FHS and the family, each in its own way, have co-responsibility for this public, in preparing this group to overcome the situations of vulnerability and the risks which can compromise the adolescents' physical and emotional integrity and their social co-existence. Hence the need for the family to maintain dialog with the adolescent and to become closer to the school; while the school, on the other hand, must open its doors to the community in which it is inserted and work on health education in consonance with the understood needs of the social surroundings.

As a result, for health education actions to be effective, it is important to consider the opinions of the individuals involved in the process, without there being imposition on the part of the educator or facilitator. And to develop team working skills, creativity and the ability to communicate, as work with adolescents requires⁽¹²⁾. As a result, when the process happens based on a dialogic methodology, the subjects can feel motivated and want to participate and learn.

Health Education must be worked on in the perspective of constructing knowledge and using the experience of the subjects at whom it is directed, without authoritarianism, making it possible for the target-public to experience changes in behavior⁽¹³⁾.

The FHS's coverage of and closeness to the community allows it to know the profile of its public and guide the scope of its work, directing it at the needs presented. Thus, in considering adolescents as poten-

tially vulnerable, the FHS must embrace this public and focus the health education actions on them. One study showed that the FHS recognizes the school space as ideal for undertaking health education actions, as it allows it to reach the collective, however, this space is still seen as for substituting the gap which is not filled in the health centers, and on most occasions, actions occur in the school which are not articulated and which lack continuity⁽¹⁴⁾.

The study cited above corroborates data found in the present research, bearing in mind that the majority of the adolescents stated that the FHS, never went to the school apart from the isolated participation of some professionals, among whom the nurse was the most evidenced. Through her political-social training directed at the process of education in health, and because of thus taking on a role as a transformative agent, this professional becomes closer to the needs of the community and family – this being extended to the adolescent⁽¹⁵⁾.

However, the responsibility for focusing health actions on the adolescent is of all the team. And for this it is necessary to extend knowledge through studies and practices, improving the care and education with the adolescents. Thus, the FHS, when present with health education actions in the school in a programmed way, gains the adolescent's trust through the link of closeness and also makes possible the publicizing of actions which must be offered to this clientele in the family health centers, the actions possibly taking place in parallel with the school activities.

In this regard, given the importance of the public policies relating to health care for adolescents, on 2007, the School Health Program was instituted in partnership with the Brazilian Ministries of Health and Education. Its objectives are to promote health and prevention of harm to health; to promote communication between the schools and health centers; and to ensure the exchange of knowledge concerning the students' health conditions, among others⁽¹⁶⁾.

This program is presented as a possibility for the promotion of adolescents' health. In this way, one study undertaken with FHS professionals showed that it is possible to extend health care for adolescents in partnership with the areas of health and education, so as to include health promotion for the adolescent public⁽¹⁷⁾. It stands out that in the context researched, although the city had adhered to the program, the activities referent to the same had not yet been initiated at the time of data collection. This understood, it is undeniable that

this program's implantation will broaden the care provided to the adolescent, however, the actions in the health education processes must be focused on the adolescent in different contexts, in the health centers, in the schools, and in the family, not being limited to the existence of a specific program alone.

It is understood that the adolescent is a dynamic being and that health education actions directed at him must also follow this dynamism in order to conquer and keep this public's interest, whether in the school or in the family health centers. Thus, in the perspective of health care for adolescents, it is essential to use the light health technologies such as embracement, conversation circles and qualified listening. Although other artifacts, such as films, materials from magazines, newspapers, group exercises and songs may be considered as appropriate for being worked on with the adolescents because they provide the socialization of discussions while at the same time allowing the facilitator to evaluate the understanding of those involved regarding the issues proposed⁽¹⁸⁻¹⁹⁾.

In this way, the use of appropriate methodologies can help in managing the health education process for the adolescent, based on an active and problematizing participation in health. Through this, the process of health education for the adolescent must be based on the comprehension of an enabling participation, that is, when the subjects participate actively in the discussions involving their lives^(5,19). In this concept, the subjects' learning must be focused within a perspective of dialog, of becoming closer, of listening, so as to develop health education activities based on the needs expressed by the adolescents.

FINAL CONSIDERATIONS

The study indicates the existence of occasions of health education in the schools, with the addressing of the following issues standing out: sexuality, alcohol and drugs, which are aligned with the adolescents' interests. Although nearly half of these were not consulted about the issues which would be addressed. The relative absence of the FHS in the school was ascertained, with the episodes of education being led by the teachers and nurses. Another aspect which deserves to be emphasized refers to the approach given by the professionals was evaluated as dissatisfactory.

The need for articulation between the professionals of the FHS and the teachers is indicated, involving the family in relation to the work with adolescents, with

the aim of minimizing the situations of vulnerability for the adolescent. Furthermore, the collaborative care between the Health and Education sectors allows the potentialization and efficacy of the actions directed at the adolescent in the health education processes in the school context.

The presence of the professional nurse was observed in the health education actions in the schools, according to the adolescents researched; however, this did not involve the team and did not happen in an organized way. In the light of this, it is reiterated that the actions directed at the adolescent must be arranged and articulated multi-professionally, and focused on this public's needs, respecting its autonomy, inducing the learning and thus leading to changes of behavior which lead them to a healthy life.

In this way, with these reflections, it is intended to contribute to the enrichment of knowledge in the field of Nursing, so as to establish partnerships between the school context, the adolescent and the family, in a perspective of becoming closer, for the promotion of health.

ACKNOWLEDGMENTS

The authors thank the National Council for Scientific and Technological Development (CNPq).

REFERENCES

1. Araújo AC, Lunardi VL, Silveira RS, Thofehrn MB, Porto AR. Transição da adolescência para a fase adulta na ótica de adolescentes. *Rev. enferm. UERJ*. [Internet] 2011;19(2) [acesso em 11 mar 2012]. Disponível: <http://www.facenf.uerj.br/v19n2/v19n2a18.pdf>.
2. Cromach FML, Burrsztyn I, Tura LFR. O olhar do adolescente sobre saúde: um estudo de representações sociais. *Ciênc. saúde colet*. [Internet] 2009;14(2) [acesso em 18 mai 2012]. Disponível: <http://dx.doi.org/10.1590/S1413-81232009000200031>
3. Gomes MC, Horta CN. Promoção de Saúde do adolescente em âmbito escolar. *Rev. APS*. [Internet] 2010;13(4) [acesso em 08 mar 2012]. Disponível: <http://www.aps.ufjf.br/index.php/aps/article/viewPDFInterstitial/897/394>.
4. Bacheladenski MS, Júnior EM. Contribuições do campo do lazer para promoção da saúde. *Ciênc. saúde coletiva*. [Internet] 2010;15(5) [acesso em 12 fev 2012]. Disponível: <http://dx.doi.org/10.1590/S1413-81232010000500031>
5. Machado MFAS, Viera NSC, Silva RM. Compreensão das mudanças comportamentais do usuário no Programa Saúde da Família por meio da participação habilitadora. *Ciênc. saúde colet*. [Internet] 2010;15(4) [acesso em 13 jan 2012]. Disponível: <http://dx.doi.org/10.1590/S1413-81232010000400027>
6. Vieira RP, Machado MFAS, Bezerra IMP, Machado CA. Assistência à saúde e demanda dos serviços na Estratégia Saúde da Família: a visão dos adolescentes. *Cogitare enferm*. [Internet] 2011;16(4) [acesso em 13 jan 2012]. Disponível: <http://ojs.c3sl.ufpr.br/ojs2/index.php/cogitare/article/download/.../17065>.
7. Callegari SMJ. *Bioestatística: princípios e aplicações*. Porto Alegre: Artmed; 2003.
8. Ministério da Saúde (BR). Conselho Nacional de Saúde. Diretrizes regulamentadoras de pesquisa envolvendo seres humanos. Resolução nº 196, de 10 de Outubro de 1996. Brasília; 1996.
9. Holanda LM, Frota MA, Machado MFAS, Vieira NC. O papel do professor na educação sexual de adolescentes. *Cogitare enferm*. [Internet] 2010;15(4) [acesso em 23 jul 2012]. Disponível: <http://ojs.c3sl.ufpr.br/ojs2/index.php/cogitare/article/download/20371/13540>.
10. Quirino GS, Rocha JBT. Sexualidade e Educação Sexual na percepção do docente. *Educar em Revista*. [Internet] 2012;(43) [acesso em 18 jul 2012]. Disponível: <http://ojs.c3sl.ufpr.br/ojs2/index.php/educar/article/view/25638/17616>.
11. Bezerra IMP, Andrade RRMP, Machado CA, Machado MFAS. Prevalência do uso de álcool em estudantes de ensino médio. *RBPS* [Internet] 2011;24(1) [acesso em 18 jun 2012]. Disponível: <http://www.redalyc.org/articulo.oa?id=40819112005>.
12. Higarashi IH, Baratiere T, Rocher S, Marcon SS. Atuação do enfermeiro junto aos adolescentes: identificando as dificuldades e perspectivas de transformação. *Rev. enferm. UERJ*. [Internet] 2011;19(3) [acesso em 14 mar 2012]. Disponível: <http://www.facenf.uerj.br/v19n3/v19n3a06.pdf>.
13. Jahn AC, Guzzo PC, Costa MC, Silva EB, Guth EJ, Lima SBS. Educação popular em saúde: metodologia potencializadora das ações do enfermeiro. *Rev. enferm. UFSM*. [Internet] 2012;2(3) [acesso em 24 jul 2012]. Disponível: <http://cascavel.ufsm.br/revistas/ojs-2.2.2/index.php/reufsm/article/.../pdf>.
14. Santos AAG, Silva RM, Machado MFAS, Vieira LJES,

- Catrib HMF. Sentidos atribuídos por profissionais a promoção da saúde do adolescente. *Ciênc. saúde colet.* [Internet] 2012;17(5) [acesso em 13 jun 2012]. Disponível: <http://dx.doi.org/10.1590/S1413-81232012000500021>
15. Silva LD, Beck CLC, Dissen CM, Tavares JP, Budó MLD, Silva HS. O enfermeiro e a educação em saúde: um estudo bibliográfico. *Rev. enferm. UFSM.* [Internet] 2012;2(2) [acesso em 15 jul 2012]. Disponível: <http://cascavel.ufsm.br/revistas/ojs-2.2.2/index.php/reufsm/article/view/2676>.
 16. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Saúde na Escola. Brasília: Ministério da saúde; 2009.
 17. Rabello SHS, Caldeira AMA, Teixeira F. Os artefatos dos media na educação em sexualidade. *Rev. Exedra.* [Internet] 2012;(6) [acesso em 25 ago 2012]. Disponível: <http://www.exedrajournal.com/docs/N6/05-Edu.pdf>.
 18. Nogueira LA, Bandeira J, Santhyago MCG. Educação em saúde na atenção ao adolescente: relato de experiência. Em extensão. [Internet] 2012;(2) [acesso em 25 set 2012]. Disponível: <http://www.seer.ufu.br/index.php/revextensao/article/view/20788/11890>.
 19. Almeida KL, Machado MFAS, Machado LDS. Pesquisa de Base Comunitária (PPBC): Uma metodologia de participação de adolescentes. *Cad. Cult. Cienc.* [Internet] 2012;11(1) [acesso em 15 set 2012]. Disponível: <http://periodicos.urca.br/ojs/index.php/cadernos/article/view/489/pdf>