

The work of physical education professionals in Family Health Support Centers (NASF): a national survey

Atuação do profissional de Educação Física nos Núcleos de Apoio à Saúde da Família: um levantamento nacional

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Abstract – This is a descriptive and quantitative national survey aimed at presenting Health Education practices (HE) developed by Physical Education professionals working at NASF in Brazil. Overall, 296 professionals participated in this study, stratified by Brazilian regions and NASF groupings. Electronic interviews were conducted regarding the activities developed at the unity where each NASF professional worked. The main activities reported were gymnastics (40.1%), and walking (29.4%), having as their priority public elderly people (68.8%), groups of hypertensive and diabetic patients (30.9%) and young people (48.3%), respectively. The most discussed topics in lectures and orientations was the importance of physical activity (51.4%) and the second most cited was the prevention/treatment of comorbidities (32.3%). The community spaces most utilized by Physical Education professionals to develop activities were: public squares, community centers and schools in the southeastern and southern regions of Brazil, and religious entities in the northeastern and Midwestern regions. In conclusion, in spite of the diversity of activities developed in different regions of Brazil, there is predominance of traditional Physical Education contents, which reflect the need of permanent education of such professionals to improve the quality of services offered to the community.

Key words: Brazil; Family health; Health education; Physical education and training.

Resumo – Estudo de levantamento nacional descritivo e quantitativo que visa apresentar as práticas de Educação em Saúde (ES) desenvolvidas pelos Profissionais de Educação Física do NASF no Brasil. Participou uma amostra representativa de 296 profissionais, estratificada pelas regiões brasileiras e modalidades de NASF. Foi realizada uma entrevista telefônica sobre a caracterização das atividades de ES desenvolvidas no NASF nas quais o profissional atuava. As principais atividades referidas foram ginástica (40,1%) e caminhada (29,4%), tendo como público participante prioritário os idosos (68,8%), grupos de hipertensos e diabéticos (30,9%) e os jovens (48,3%), respectivamente. O primeiro tema mais abordado nas palestras e orientações em saúde foi sobre a importância da atividade física (51,4%) e o segundo mais citado foi prevenção/tratamento de comorbidades (32,3%). Os espaços comunitários mais utilizados pelo Profissional de Educação Física, além da Unidade de Saúde da Família, para realização das atividades de ES foram: praças, centros comunitários e escolas, nas regiões Sudeste e Sul, e entidades religiosas no Nordeste e Centro-Oeste. Conclui-se que, apesar da diversidade das ações promovidas nas diferentes regiões do Brasil, há uma predominância de atividades baseadas nos conteúdos tradicionais da Educação Física, refletindo a necessidade de educação permanente dos profissionais para potencializar a oferta de serviços à comunidade.

Palavras-chave: Brasil; Educação em saúde; Educação física e treinamento; Saúde da família.

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INTRODUCTION

The Primary Health Care (APS) is the structural basis of actions and services of the Unified Health System (SUS). The principles that guide it include an articulating function in the system based on comprehensive care and health promotion. According to the legislation, APS is the main gateway to SUS¹, as it is characterized as the first contact of citizens with health services.

In order to strengthen and broaden the scope of primary care, the Family Health Support Center (NASF) was created to offer a specialized health team for activities and services offered by the APS reference teams². The work process in this multidisciplinary team is guided in the theoretical and methodological foundations of the Matrix Support, which seeks, from horizontal organizational, to overcome the fragmented work logics. The reference staff (Family Health Team) and the matrix team (NASF) act in a shared way in solving community health problems, whether through assistance or educational support related to the training of professional specialties.

Different professions can work in NASF by local demand identified by management in partnership with the Family Health Team (ESF) and community. The Physical Education professional is among the five most recruited categories in NASF, present in 49.2% of multidisciplinary teams³. The presence of this professional in the matrix team may favor the improvement of health promotion and educational practices and improve the quality of the work process⁴.

Health education (ES) practice is a process of learning and sharing that allows professionals and community to build significant knowledge on various topics related to health. It is a social practice focused on critical reflection of different realities based on the recognition of the everyday problems experienced by individuals or social groups⁵. There has been a growing focus to the educational activities in APS for guidance and counseling of physical activities^{4,6,7}. The Health Promotion Policy includes this issue as a management priority, promoting programs and projects involving physical activity, and the results of external evaluation indicate effectiveness for change in the health habits of the population⁸.

Studies with NASF teams in southern Brazil indicate that the educational practices developed by Physical Education professionals are mostly limited to intervention in groups, prescriptive in nature and focused on the disease^{9,10}. The information in this study reflects the implementation of NASF in the country and the challenging role implicit in this proposal for Physical Education, since there is lack of knowledge of the profession about the dynamics of working in a matrix team of APS. It was not found in scientific literature national or regional investigations showing consistent results about the central theme of this study. Therefore, this study aimed to present ES practices developed by Physical Education professionals of NASFs in Brazil and its regions.

METHODOLOGICAL PROCEDURES

This is an exploratory and descriptive research with quantitative approach aimed at presenting data, indicators and trends observed¹¹. The research project was approved by the Ethics Committee for Research with Human Beings (CEP) of the Federal University of Santa Catarina (Process No. 197/2010). The reading of the Informed Consent Form was performed to Physical Education professionals interviewed, and subsequently, authorization for data collection was requested, requiring that the subject verbally accepted or not to participate.

Participants were Physical Education professionals of NASFs in Brazil, accredited in the National Register of Health Facilities (CNES) by January 2011. To estimate the population size, the list of physical education professionals accredited to NASF was requested from the State Departments of Health, and data were confronted with information available at CNES. A total of 738 PE professionals were accredited to NASF in Brazil. Codes of physical education professionals selected for consultation were: physical evaluator, athletic trainer, physical trainer, coach of individual and collective sports (except soccer), laboratory technician and sports supervision and soccer coach¹².

Sampling procedures for finite populations adopted tolerable error of 5% for frequency of 50% to reach the largest sample possible, since the study had different outcomes. In the end, the sample size required was 253 subjects. An addition of 20% of the initial sample was calculated in order to compensate for possible losses and refusals, totaling 303 professionals working at NASF. The process of selection of subjects was random, stratified and self-weighting of two strata: regions of Brazil (North, Northeast, Midwest, Southeast and South) and NASF modalities (NASF 1, NASF 2 and NASF via intermunicipal consortium)¹³. This model ensures sample representativeness for all regions of Brazil, considering the proportionality of NASF modalities accredited in each region.

Physical Education professionals belonging to the permanent and temporary framework of the Municipal Health Department included in NASF team for more than three months, excluding those that during data collection were inactive, with leave of different natures or vacation, away or at the disposal of other organs of the municipality.

The interview guide was prepared in order to assess the NASF implementation process and the work of the Physical Education professional, which was submitted to face and content validation, consisting of a panel of three experts and clarity and enforceability performed with 10 professionals not selected for the sample, from the northeastern and southeastern regions. Finally, the reproducibility procedure in sample representative of 46 subjects proportionally distributed among the regions of Brazil was applied. The interview was applied by two different interviewers at different times, separated by a seven-day interval (test - retest). The average final agreement coefficient of the instrument was moderate ($\kappa = 0.62$), meeting the validity criteria¹⁴.

The instrument consisted of 59 questions divided into the following sessions: sociodemographic data ($n = 6$), working conditions ($n = 29$) and matrix support ($n = 24$). To characterize the ES component, the physical environment was verified for the performance of group activities, the type of activity developed, the target audience and the main topics discussed. The respondent could indicate up to three answers, following a descending order of importance.

Data collection occurred from January to March 2011 by a team of interviewers previously trained with theoretical and practical modules to assist in operating the telephone interview program (Skype, Zoiper, JustVoip). The work team received Interviewer's Manual, the data collection instrument, computer and audio equipment for the implementation of data collection. All interviews were recorded in printed questionnaire by the interviewer in order to avoid losses and failures during data collection procedure.

The initial contact was made with the immediate NASF coordination and then with the Physical Education professional. The interviews were conducted according to the Physical Education professional's availability, which could be scheduled up to two weeks after the first contact. The limit of 10 contact attempts and rescheduling of up to five times was adopted.

The characterization of ES practices developed by Physical Education professionals of NASF, in Brazil and regions, was analyzed using descriptive statistics of central tendency. The definition of categories based on the answers given was carried out by systematic reading of answers and grouping of terms highlighted in the speech.

RESULTS

The final sample included 296 Physical Education professionals of NASF with response rate of 97.7%. Among the 2.3% of losses and refusals, contact with four professionals could not be achieved, even after 10 attempts. Therefore, losses were not replaced because there are no eligible professionals of the same type of NASF and region of Brazil.

Physical Education professionals reported developing educational activities in the UBS (89.5%) and community (92.9%). The three main locations used in the community were public spaces for leisure (squares, parks, fields, streets), religious entities and community centers. By analyzing the characteristics of regions, the school was mentioned as the third space most used by NASF in the southeastern and southern regions, and along with religious entities, it was the second most mentioned by professionals in the northeastern and midwestern regions (Table 1).

The main activities developed, in order of importance, were gymnastics, educational lectures and relaxation, but walking, recreational activities and games were also cited (Table 2). In the Northern region, walking was the most cited activity and recreational games were the second and third most cited in the Midwestern and southeastern regions, respectively.

With regard to the target audience of educational activities, the population groups with the highest participation in activities were elderly with

high blood pressure or diabetes, and young people (children and adolescents). When stratified by regions, differences were observed because in the northern and southern regions, young people are seen as the second most attended public and specific groups (pregnant women, chronic pain, caregivers, etc.) as third (Table 2).

Table 1. Health Education actions developed at the Family Health Support Centers, according to region. Brazil 2011.

Variables	BR	N	NE	SE	S	MW
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Activity in the Health Unit						
Yes	265(89.5)	14(87.5)	126(86.9)	79(91.9)	33(97.1)	13(86.7)
No	31(10.5)	2(12.5)	19(13.1)	7(8.1)	1(2.9)	2(13.3)
Activity in the community						
Yes	275(92.9)	15(93.8)	133(91.7)	79(91.9)	34(100.0)	14(93.3)
No	21(7.1)	1(6.3)	12(8.3)	7(8.1)	-	1(6.7)
Place of Activity in the community						
Priority 1						
Public leisure spaces	123(45.1)	5(33.3)	61(46.6)	38(48.1)	15(44.1)	4(28.6)
Private leisure areas	15(5.5)	1(6.7)	8(6.1)	5(6.3)	-	1(7.1)
Religious Entities	40(14.7)	3(20.0)	19(14.5)	11(13.9)	6(17.6)	1(7.1)
Community Centers	44(16.1)	4(26.7)	20(15.3)	9(11.4)	8(23.5)	3(21.4)
Schools/IES	31(11.4)	1(6.7)	14(10.7)	12(15.2)	1(2.9)	3(21.4)
Others	20(7.3)	1(6.7)	9(6.9)	4(5.1)	4(11.8)	2(14.3)
Priority 2						
Public leisure spaces	113(43.5)	4(26.7)	63(49.6)	29(40.3)	13(39.4)	4(30.8)
Private leisure areas	11(4.2)	2(13.3)	3(2.4)	5(6.9)	1(3.0)	-
Religious Entities	35(13.5)	3(20.0)	13(10.2)	11(15.3)	6(18.2)	2(15.4)
Community Centers	31(11.9)	2(13.3)	13(10.2)	9(12.5)	6(18.2)	1(7.7)
Schools/IES	28(10.8)	1(6.7)	13(10.2)	7(9.7)	5(15.2)	2(15.4)
Others	42(16.2)	3(20.0)	22(17.3)	11(15.3)	2(6.1)	4(30.8)
Priority 3						
Public leisure spaces	70(36.6)	4(33.3)	34(34.3)	13(28.3)	14(56.0)	5(55.6)
Private leisure areas	13(6.8)	2(16.7)	6(6.1)	4(8.7)	1(4.0)	-
Religious Entities	16(8.4)	-	10(10.1)	5(10.9)	1(4.0)	-
Community Centers	27(14.1)	3(25.0)	2(17.0)	2(4.3)	2(8.0)	3(33.3)
Schools/IES	22(11.5)	-	8(8.1)	10(21.7)	4(16.0)	-
Others	43(22.5)	3(25.0)	24(24.2)	12(26.1)	3(12.0)	1(11.1)

BR: Brazil; N: North; NE: Northeast; SE: Southeast; S: South; MW: Midwest

The main topic addressed among educational activities of NASF referred to physical activity, health and quality of life (Table 3). Comorbidities were the second most developed theme in educational lectures held by physical education professionals of NASF in Brazil and the main topic addressed in the southern region. Risky behaviors such as use of drugs, cigarettes and alcohol, sexually transmitted diseases and violence were the third most discussed topic in lectures. Nutrition and care to specific groups appeared as the third most discussed topic in the northern and southeastern regions.

Table 2. Activities and participants of Health Education actions carried out by the Family Health Support Center according to region. Brazil 2011.

Variables	BR	N	NE	SE	S	MW
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Activity performed						
Priority 1						
Walking	82(29.4)	9(60.0)	42(31.6)	17(22.1)	9(26.5)	5(35.7)
Gymnastics	112(40.1)	4(26.7)	56(42.1)	32(41.6)	13(38.2)	7(50.0)
Recreational activities	3(1.1)	-	2(1.5)	1(1.3)	-	-
Lectures / Guidelines	45(16.1)	1(6.7)	20(15.0)	15(19.5)	8(23.5)	1(7.1)
Therapeutic Activities	31(11.1)	1(6.7)	13(9.8)	12(15.6)	4(11.8)	1(7.1)
Others	6(2.2)	-	-	-	-	-
Priority 2						
Walking	46(18.2)	1(9.1)	27(21.8)	11(14.7)	5(16.7)	2(15.4)
Gymnastics	105(41.5)	5(45.5)	50(40.3)	32(42.7)	13(43.3)	5(38.5)
Recreational activities	18(7.1)	-	7(5.6)	5(6.7)	3(10.0)	3(23.1)
Lectures / Guidelines	61(24.1)	4(36.4)	30(24.2)	19(25.3)	6(20.0)	2(15.4)
Therapeutic Activities	23(9.1)	1(9.1)	10(8.1)	8(10.7)	3(10.0)	1(7.7)
Others	-	-	-	-	-	-
Priority 3						
Walking	30(14.6)	-	12(13.8)	12(19.4)	5(19.2)	1(8.3)
Gymnastics	33(16.0)	1(9.1)	18(20.7)	7(11.3)	5(19.2)	2(16.7)
Recreational activities	27(13.1)	2(18.9)	9(10.3)	12(19.4)	1(3.8)	3(25.0)
Lectures / Guidelines	75(36.4)	4(36.4)	37(42.5)	20(32.3)	9(34.6)	5(41.7)
Therapeutic Activities	33(16.0)	4(36.4)	11(12.6)	11(17.7)	6(23.1)	1(8.3)
Others	8(3.9)	-	-	-	-	-
Target audience						
Priority 1						
Young people	13(4.6)	-	7(5.1)	2(2.4)	3(9.4)	1(6.7)
Adults	14(5.0)	2(13.3)	4(2.9)	7(8.4)	1(3.1)	-
Elderly	194(68.8)	9(60.0)	100(73.0)	56(67.5)	19(59.4)	10(66.7)
*Hiperdia	55(19.5)	4(26.7)	22(16.1)	17(20.5)	8(25.0)	4(26.7)
Specific Groups	6(2.1)	-	4(2.9)	1(1.2)	1(3.1)	-
Priority 2						
Young people	57(25.9)	4(30.8)	27(24.5)	18(27.7)	7(31.8)	1(10.0)
Adults	40(18.2)	2(15.4)	26(23.6)	8(12.3)	3(13.6)	1(10.0)
Elderly	35(15.9)	2(15.4)	16(14.5)	9(13.8)	5(22.7)	3(30.0)
*Hiperdia	68(30.9)	2(15.4)	33(30.0)	24(36.9)	6(27.3)	3(30.0)
Specific Groups	20(9.1)	3(23.1)	8(7.3)	6(9.2)	1(4.5)	2(20.0)
Priority 3						
Young people	98(48.3)	4(50.0)	54(50.9)	25(43.1)	10(52.6)	5(41.7)
Adults	20(9.9)	-	9(8.5)	7(12.1)	2(10.5)	2(16.7)
Elderly	16(7.9)	1(12.5)	12(11.3)	1(1.7)	2(10.5)	-
*Hiperdia	36(17.7)	1(12.5)	18(17.0)	12(20.7)	2(10.5)	3(25.0)
Specific Groups	33(16.3)	2(25.0)	13(12.3)	13(22.4)	3(15.8)	2(16.7)

BR: Brazil; N: North; NE: Northeast; SE: Southeast; S: South; MW: Midwest. * Educational groups of Hypertension and Diabetes.

Table 3. Description of the main topics addressed in Health Education actions in NASF, Brazil, 2012.

Variables	BR	N	NE	SE	S	MW
	n(%)	n(%)	n(%)	n(%)	n(%)	n(%)
Topics addressed						
Priority 1						
Physical Activity and Quality of Life	149(51.4)	10(62.5)	72(51.8)	40(46.5)	15(44.1)	12(80.0)
Risk behaviors	18(6.2)	1(6.3)	10(7.2)	4(4.7)	2(5.9)	1(6.7)
Other Comorbidities	84(29.0)	5(31.3)	38(27.3)	25(29.1)	15(44.1)	1(6.7)
Nutrition	19(6.6)	-	11(7.9)	7(8.1)	1(2.9)	-
Specific Groups	8(2.8)	-	3(2.2)	4(4.7)	1(2.9)	-
Others	12(4.1)	-	5(3.6)	6(7.0)	-	1(6.7)
Priority 2						
Physical Activity and Quality of Life	89(31.6)	4(25.0)	47(34.6)	24(29.3)	10(30.3)	4(26.7)
Risk behaviors	29(10.3)	2(12.5)	11(8.1)	8(9.8)	7(21.2)	1(6.7)
Other Comorbidities	91(32.3)	6(37.5)	43(31.6)	28(34.1)	10(30.3)	4(26.7)
Nutrition	21(7.4)	-	11(8.1)	5(6.1)	2(6.1)	3(20.0)
Specific Groups	30(10.6)	3(18.8)	14(10.3)	7(8.5)	3(9.1)	3(20.0)
Others	22(7.8)	1(6.3)	10(7.4)	10(12.2)	1(3.0)	-
Priority 3						
Physical Activity and Quality of Life	90(37.7)	2(13.3)	46(39.0)	25(37.3)	12(44.4)	5(41.7)
Risk behaviors	28(11.7)	2(13.3)	13(11.0)	7(10.4)	4(14.8)	2(16.7)
Other Comorbidities	53(22.2)	3(20.0)	29(24.6)	14(20.9)	4(14.8)	3(25.0)
Nutrition	14(5.9)	2(13.3)	3(2.5)	7(10.4)	2(7.4)	-
Specific Groups	20(8.4)	1(6.7)	10(8.5)	6(9.0)	3(11.1)	-
Others	34(14.2)	5(33.3)	17(14.4)	8(11.9)	2(7.4)	2(16.7)

BR: Brazil; N: North; NE: Northeast; SE: Southeast; S: South; MW: Midwest.

DISCUSSION

In general, Physical Education professionals of NASF reported developing health education activities in their routine work, using public spaces available in the community to promote the practice of physical activity and health guidelines. The educational activities developed by Physical Education professionals of NASF occur at UBS or other community spaces. A study conducted in southern and northeastern Brazil indicates low prevalence of activities performed at the premises of UBS, compared to users' needs⁴. The factors most identified in literature were the lack of material and poor physical structure of UBS¹⁵.

The optimization of public spaces is a positive factor and indicated in the NASF regulations. However, it is considered that the community UBS should be an environment that promotes the practice of physical activity¹⁶ and other social practices, being the reference in health in the territory. The implementation of actions within and outside the community can be

appointed also as an approaching element and continuous participation of ESF and actions developed by the NASF team, since ESF may eventually be unable to regularly move to other community spaces.

Among sites listed in the community for health practices, the use of squares, streets, community centers, schools and religious entities stands out. This result was similar to that found in the Action and Health Project of Guanambi, Bahia, where the practice of physical activities in APS was encouraged, and PE professionals used squares, parks, fields and community centers, in addition to the structure of Basic Health Units¹⁷.

Most Brazilian schools do not have health intervention programs, and when they are developed, the prevailing approach is healthy eating and physical activity, which are efficient to reduce physical inactivity¹⁸. The Ministries of Health and Education have sought to enlarge health actions in schools through programs such as Health and Prevention in Schools (SPE)¹⁹ and the School Health Program (PSE)²⁰. The engagement of young people in educational practices may be associated to the fact that PE professionals develop prevention, promotion and health care actions in the public school network. Thus, although young people are the least assiduous in the premises of UBSs, the implementation of PSE can have approached health professionals to that public within the school environment.

Importantly, the site for the regular practice of physical activity can be chosen according to the preference of participants, prioritizing the use of accessible public spaces near the community²¹. However, this choice is not always based on the choice of subjects but on the availability of sites suitable for the development of activities²²⁻²⁴.

Among the activities offered and performed by professionals, there was predominance of gymnastics and walking, traditional in Physical Education. The NASF guidelines stress that physical education professionals should develop activities addressing the various elements of the body movement culture, encouraging the treatment of chronic diseases and increasing the level of physical activity¹⁰. The Health in the Square Project developed in 55 sites in the city of Araraquara / SP showed that there is good acceptance by adults and older adults to Lian-Gong and Tai Chi Chuan activities²⁵. These results demonstrate that body practices can be included in the routine of collective activities of Physical Education professionals of NASF, reaching a favorable adherence in the community, as with gymnastics and walking activities.

Lectures and group guidelines were frequently reported among Physical Education professionals of NASF. Study conducted with Family Health Strategy professionals showed that counseling for physical activity was performed more frequently in individual consultations and home visits²². Furthermore, educational activities in groups were highlighted as one of the most important and well accepted activity among basic team professionals²⁶. These activities are considered fundamental but need appropriate structure and interdisciplinary methodologies to motivate the permanence and commitment of participants²⁷.

Making a comparison among the main activities developed by other professionals of NASF, there are reports on the performance of nutritionists from São Paulo who mentioned educational groups, home visits and individual care as main activities²⁸, and physiotherapists reported programs of aerobic exercise and stretching²⁹. Among speech therapists from the city of Recife, it was found that the matrix support actions of NASF held in combination with the basic team overlapped clinical care rehabilitation³⁰, which demonstrates organization of the staff in meeting the demand for shared consultation, which as recommended, should only take place in specific cases¹³.

In general, participants of Physical Education activities in NASF were composed of groups of female elderly or with some co-morbidities, followed by young individuals. According to Ordinance No. 154¹³, the actions developed by NASF professionals should not be directed only to groups most vulnerable to diseases or people who have fallen ill. Siqueira et al.⁴ also showed that patients of high blood pressure, diabetes and neurological diseases, in addition to those making use of medicines were the groups that received more counseling on regular physical activity.

In health guidelines, the main contents addressed have been physical activity, health and quality of life. The guidance for the practice of physical activity is a good way to promote health among SUS users because, knowing its importance, the tendency is for them to adopt healthier behaviors²³. It is expected that NASF professionals pay more attention to cross-sectional issues that impact on health, and not necessarily to the disease. NASF laws and guidelines indicate as role of NASF professionals to interact with other social policies in the areas of education, culture, labor and others¹³, reinforcing the relevance of subjects least reported by participants.

This study shows some limitations, among these, the difficulty to make contact with professionals from certain localities, especially in the northern region and inland municipalities. The fact that the interview be conducted via telephone not always allowed a quality transmission in distant locations. On the other hand, it is noteworthy that no professionals were excluded merely due to their location, but the difficulty of contacting some professionals either because there was no phone in the workplace or to the difficulty in understanding the speech during the interview may have hampered their acceptance and inclusion.

CONCLUSIONS

ES activities carried out by Physical Education professionals of NASF occurred more frequently in UBS and other spaces available in the community. The main places mentioned were public spaces for leisure, schools and religious entities. Gymnastics and relaxation were the main ES actions carried out, in general, for groups vulnerable to diseases or with some co-morbidity. In health guidelines, the main topics discussed were related to the importance of physical activity for health, quality of life and disease

prevention. It was concluded that there is need to expand activities and services offered to the community, so that, regardless of age or presence of diseases, all SUS users have access to ES practices developed.

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