

Mismatches between professional education and care needs of the adolescents in Primary Health Care*

Desencontros entre formação profissional e necessidades de cuidado aos adolescentes na Atenção Básica à Saúde (resumo: p. 19)

Desencuentros entre formación profesional y necesidades de cuidado a los adolescentes en la Atención Básica de la Salud (resumen: p. 19)

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The aim of this study was to discuss features related to the formative process for managers and professionals of Primary Health Care (PHC) in adolescent health care. It was a qualitative research involving seven managers and 17 professionals from PHC (semi-structured interviews), ten professionals from the Family Health Support Group and 47 adolescents (focus groups). The analysis was based in the hermeneutic-dialectical perspective and the concept of comprehensive care was used to guide the theoretical debate. Professionals and managers find that undergraduate and continuing education is incipient, not covering comprehensive care. The adolescents highlighted the lack of preparation of professionals as obstacles in their linkage to the service. Larger investments are needed in the professional education as a way to improve the practice of PHC services, in order to make them more coherent and appropriate to the logic of care and the needs/lifestyles of adolescents.

Keywords: Adolescent Health. Primary health care. Public health. Higher education. Continuing education.



Introduction

Adolescence, a social construction of our culture, corresponds to a dynamic phase of human development between childhood and adulthood that is variable, even among reference sources¹. According to the World Health Organization², adolescence encompasses the age range from ten to 19 years. Correspondingly, the Ministry of Health³ adopts this same chronological parameter, although the Child and Adolescent Statute⁴ defines this phase as a period from 12 to 18 years.

Moreover, the chronological criterion used to delimit adolescence became very useful in the biomedical definition of parameters for scientific investigations and public policymaking⁵. However, it became insufficient to deal with the concrete and historical subject – the adolescent, from a sociological perspective⁶.

Adolescence is a complex phenomenon, product of the interaction between processes of biological and sociocultural development⁷. Using this lens, the understanding of adolescence substantiates the idea of a continuous identity construction, considering the relational and definitely contingent character of the identities of individuals and groups⁸.

Adolescence is therefore engendered in intersubjectivity, being woven into the relationships with the world and constituting its historicity⁶ – an aspect that “signals the uniqueness in the formative process of individuals and the collective construction of shared beliefs and values in the cultural dimension” (p. 80). In fact, the ways of walking in life reflect the vulnerability¹⁰ of adolescents, facing the complex process of health and illness, in turn accentuated in contexts of inequity and stigma.

Therefore, vulnerability would not be something natural to adolescence, as it would present itself as a perspective of the dialectic of the subject’s way of being/living in the process of becoming¹¹ an adolescent¹². Thus, adolescents should not be constituted as target population for interventions, but instead as a set of social relations that need a sensitive approach to ethnic, gender, class, etc., since adolescence would be a potentiality¹¹.

Not surprisingly, any adolescents’ health care pathway is complex, especially from the perspective of comprehensive care¹. In the logic of organization of health care networks¹³, the Family Health Strategy (FHS) should also be the primary locus for continuous/coordinated care and professionals at this level of attention would be the subjects with the power to build shared actions in the territory and produce an expanded clinical approach⁹.

Such perspective places its bets on the kind of care directed towards specific territories and its consequent approximation with the life context of adolescents, the existence of work processes that are porous to interdisciplinary action, intersectoral articulation and the possibility of a perennial space for inter-subjective exchanges capable of producing dialogic relations and promote care networks^{14,15}. Therefore, the FHS would provide at the same time individualized care for adolescents, as well as the identification of needs that go beyond those clinically demanded and defined by biomedical rationality, further expanding them to aspects that surpass social medicalization¹⁶.



From this perspective, fostering professional competence in adolescent care at the theoretical and technical levels remains a major challenge¹⁷. Moreover, both in the training process during the undergraduate process¹⁸, as well as in the actions of in-service permanent education¹⁹, there are gaps in the approach to attributes that are inherent to adolescent health and, consequently, it is confronted with professionals lacking the adequate competencies to deal with specific demands of this social group²⁰. This issue also compromises the quality of the FHS as a priority entry point for the population of the assigned territory as a whole²¹.

In this area, aspects related to the training process of health workers for the production of adolescent health care are discussed, taking into account the academic experience and in-service training to qualify the work process within the scope of Primary Health Care.

Method

It is a qualitative study²², researching the meanings attributed to facts, relationships and practices for the production of adolescent health care. The data were produced through interaction with interlocutors at the Municipal Health Department at five Family Health Units (FHU). Four of them were in the urban area, and one in the rural area, in a municipality in southwestern Bahia (796 km from Salvador), a regional health headquarters. Family Health Strategy (FHS) coverage was 82%, with 19 Family Health Teams (EqSF) and two Family Health Support Group (NASF) teams²³.

The choice of EqSF was made by a previous survey, through contact with managers from all FHU. The field exploration covered data concerning the professionals' working time and a brief report of the adolescent care actions developed by the EqSF. The selection covered different contexts of location of the FHU: rural and urban; peripheral and central neighborhoods.

Data production (Table 1) took place between September and November 2017. The study interlocutors (81 subjects) and the respective techniques were composed by: 1) seven managers - semi-structured interviews; 2) seventeen PHC professionals - semi-structured interviews; 3) ten professionals from two Family Health Support Center (NASF) teams - grouped into a focus group; 4) 47 adolescents - subdivided into five focus group sessions (one session for each selected FHU), respectively with twelve, nine, eleven, nine and six adolescents per group.



Figure 1. Participants' description, inclusion criteria and data production strategies

Groups (code)	Group Interlocutors (n°)	Selection intentionality / Inclusion criteria	Data production	
			Technique(n°)	Local
Managers (M)	<p>Municipal Secretary of Health (01)</p> <p>PHC Managing Director (01)</p> <p>Oral Health Coordinator (01)</p> <p>Institutional Supporters (04)</p>	<p>Interlocutors of municipal management capable of generating institutional learning in actions related to adolescent care;</p> <p>Ability to express meanings and meanings about adolescent care at the municipal level;</p> <p>Minimum of six months of exercise in the position;</p> <p>Work in PHC management and know the selected FHU</p>	Semi structured interview (24)	Municipal Secretary of Health
EgSF Professionals (P)	<p>Community Health Agent (ACS) (05)</p> <p>Dentists (02)</p> <p>Nurses (07)</p> <p>Doctors (03)</p>	<p>FHU interlocutors who performed adolescent care actions in the FHUE or territory;</p> <p>At least one professional from each FHU elected;</p> <p>Compose a diversity of formations to enable the debate about the different nuclei of knowledge;</p> <p>One ACS from each FHU (indicated by the team among the most active);</p> <p>Willingness to attend the interview</p>		Family Health Unit (FHU)
NASF Professionals (NP)	<p>Social Workers (03)</p> <p>Physical Educator (01)</p> <p>Pharmacist (01)</p> <p>Physiotherapists (02)</p> <p>Nutritionists (02)</p> <p>Psychologist (01)</p>	<p>FHU interlocutors who performed adolescent care actions in the FHU and / or territory;</p> <p>Compose a diversity of formations to enable the debate about the different nuclei of knowledge;</p> <p>NASF professionals with technical skills and responsibilities in carrying out actions at elected FHUs;</p> <p>Willingness to participate in focus group</p>	Focus group (06)	Family Health Unit (FHU)

Continua.

Figure 1. Participants' description, inclusion criteria and data production strategies

Groups (code)	Group Interlocutors (n°)	Selection intentionality / Inclusion criteria	Data production	
			Technique(n°)	Local
Service Users (A)	Adolescents (47)	<p>Interlocutors who bring contributions from the perspective of being users of services, the center of the process of health care actions;</p> <p>Are registered in the EqSF included in the study;</p> <p>They are between 10 years old (with parental consent) and 19 years old (with consent);</p> <p>As a criterion for the selection of adolescents, the ACS;</p> <p>Availability to participate in Focus Group</p>	Focus group (06)	Family Health Unit (FHU)

Moreover, the justification for the choice of different instruments for different groups of interlocutors was due to the methodological strategy that sought the involvement of diversity of subjects – both in quantity and quality - without disjunction²². A greater number of adolescents was eligible for the study and in order to contemplate greater participation, the focus group resource was used also enabling the production of data in a more interactive and problematic context^{24,25}. This feature, too, was used for NASF professionals applying a similar rationale.

On the other hand, managers formed a restricted group and therefore compatible with individualized data production. Similarly, in the professionals' case, the interview was the chosen technique, due to the need to understand the formative singularities present in the different cores of knowledge. Even though it was a large group, there was representation regarding five FHU and selectable by saturation²⁶.

Subsequently, the interviews and focus group sessions were recorded, fully transcribed and coded with letters and Arabic numbering. The letters M were used for managers, P for FHS professionals, NP for NASF professionals and A for adolescents.

To analyze and interpret²⁷ the interviews and focus groups, the data were sorted according to the general reading of the transcribed material and a primary organization of the different empirical data. The material was sorted and classified, the transcripts were read exhaustively and the context units were selected, grouped and categorized (Table 2). The arguments of the focus groups and interviews were confronted, followed by a comparison between the different discourses in the dialectical confrontation of ideas and positions of the subjects. For the final data analysis²⁷, the narratives were cross-cut, identifying consensus, mediation, agreement (hermeneutic movement) and controversies, dissent, criticism (dialectical movement) fostering intersubjectivity for the production of comprehensive and critical interpretation^{22,28}.

Table 2. Thematic Categories

Units of Context	Thematic Categories
<ul style="list-style-type: none">• Incipient and superficial and combined with child health• There was no specific curricular component• Lack of practical experiences in the internships• Punctual and fragmented actions• Teaching focused on biomedical issues• Teaching with traditional methodologies and focused on content accumulation	Deficiencies in the academic formation of health professionals regarding adolescent care
<ul style="list-style-type: none">• Insufficient and do not address adolescent health• NASF managers and professionals unprepared for institutional / matrix support to health teams• Turnover of professionals - constant resumption and repetition of priority themes• Restricted Use of Tele-health	Permanent health education and the invisibility of adolescents
<ul style="list-style-type: none">• Distrust of the professional	Professional unpreparedness and adolescent perception

Finally, the results and discussion were grouped into three thematic categories: I) Deficiencies in the academic formation of health professionals regarding adolescent care; II) Permanent education in health and the invisibility of adolescents; and III) Professional unpreparedness and adolescent perception (Figure 2).

The research was approved by the Research Ethics Committee of the Federal University of Bahia (Opinion 2,250,531). The investigation started with the signing of the Free Informed Consent form - managers, professionals, adolescents (≥ 18 years) or legal guardian - and the Free and Informed Assent form (adolescents ≤ 18 years).

Results e discussion

Shortcomings in the academic formation of health professionals regarding adolescent care

To understand these results, this category is based on the perceptions of professionals of the Family Health Strategy.

Thus, doctors and nurses considered their formative process incipient and superficial in the context of adolescent health. This is because, at the undergraduate level, there was no specific curricular component, while the approaches, whenever present in the curriculum were linked to the child's health. There was also greater emphasis on the topic related to childhood, without a thorough focus on the singularities of adolescent care. Moreover, the topics related to adolescent health did not crosscut other curriculum components either, characterizing a formative gap. The fragments below exemplify such findings:

It is very incipient to work with a teenager [...] it is 'child and adolescent health', but the child's health is very extensive [...]. We end up not approaching and not having this preparation to deal with the public, so when the teenager arrives,



there is an initial shock: - My God, a teenager! Because you are prepared to have a prenatal consultation, child care, family planning, but not prepared to meet the demands of the teenager. (P5 - Nurse)

I had my undergraduate degree incorporated in “child and adolescent health”, it was just one thing. It turned out that the focus was much greater on children. Teenagers were left aside [...] the teacher taught more about children. (P7 - Doctor)

However, the educational limitations in undergraduate health are historical, as per the process of training on comprehensive care¹⁸. Regarding adolescent health, for example, there has been the insertion of broader perspectives in the curriculum matrix in some courses²⁹, however, they are still insufficient for a professional performance consistent with comprehensive care³⁰.

Not by chance, the professionals interviewed revealed themselves as insecure in clinical conducts, unless the adolescent fit into any of the FHU programmatic actions. In general, the curriculum of health courses does not deal properly with themes related to adolescence, often restricted to a conservative and technical approach to the reproductive process / sexuality¹⁷.

Consequently, care practices are often organized on the basis of programmatic actions, i.e. the set of professionals' actions is concentrated in certain population groups and/or specific diseases^{21,30} to the detriment of comprehensiveness³¹ (in the territory and the FHU), contrary to an integral PHC³² and an expanded clinic approach⁹.

In addition, while programs targeting maternal and child groups and the elderly are heavily implemented, actions targeting adolescents remain marginal in government policies³³ and in professional practices^{21,30,34}. Moreover, health care actions aimed at adolescents are practically nonexistent in PHC services; therefore, internships in services do not provide the undergraduate with the meaningful experience for their academic education and compromises the clinical and relational competence required for qualified care. Nevertheless, the experience as a student, according to interviewees, was limited to the performance of educational activities at school, contrary to the perspective of comprehensive care (both technical and relational), as the following excerpt points out:

In my undergraduate degree, when we do the discipline ‘child health’, it is focused on the teenager. I had a brief contact from a theoretical perspective, and in practice the service was already working as it is today. So when we went to work with teenagers, they used to put creativity to develop something for teenagers, usually it was at school, because the unit did not receive this audience for us to give care. (P1 - Nurse)

The experience of the student in other spaces that transcend the health unit in practices related to ABS is of paramount importance in the formative path, because “the



formative process does not happen only at school. It happens in multiple spaces, just as there are multiple learning processes that occur in each of these spaces³⁵ (p. 106). In this perspective, the teaching-learning scenarios should not be restricted to formal places of professional practice, but should include “multi-referential spaces”, through the plurality of glances directed to a reality and the languages needed to translate it³⁶. However, such learning spaces cannot be a “dressing” to the set of actions necessary to the teaching process aimed at the production of integral care.

From this perspective, the diversity of teaching-learning scenarios that make up the student’s insertion itinerary enhances the preparation for the comprehensiveness of care, because within the daily actions of the institutions and the community, the ways of creation and appropriation of production, reproduction and reinvention of health and ways of walking in life are expressed³⁷.

Thus, it is necessary to provide to undergraduate students in the health area moments of articulation of concepts, perceptions and sensations to produce knowledge from teaching practices guided by comprehensiveness from a critical and problematic perspective^{18,37,38}. Nevertheless, it is believed that the reflection on the aspects experienced in theory and practice (intersubjectivity and procedures) can strengthen the formation of future professionals involved with ways of organizing services so that they receptive to adolescents and foster work processes that are attentive and resolute to the demands of this social group. Thus, experiences of fragmented and uncompromised care experienced in undergraduate studies will not be reproduced in the daily work of PHC services, as evidenced in the following statement:

Since my graduation, we have hardly done any teen-oriented things. It was more on children, elderly, prenatal, preventive, hardly ever, honestly, we rarely had a lecture since graduation. I don’t think it’s a problem now, that teens are more out of the program, I think it’s from the past. At the time of graduation, what we would talk to the teenager was this: drugs, sexuality, abuse. At the individual level, it was very faulty, it has not existed since graduation. (P13 - Nurse)

Thus, inadequate training of health professionals regarding adolescent health care has been reproduced in daily life at PHC services. Therefore, by using the FHU as a field of practice and not experiencing comprehensive and diversified actions (clinical and educational) directed towards the adolescent, the students are able to reflect on their future practices, essentially due to the lack of stimulation and / or because not knowing how to do it. As a result, professionals elaborate partial formulations about the adolescent and the modes of care that, in turn, fragment the body “[...] as an instrument of diagnosis, prevention or therapy, with a dual function: as an instrument in its relationship with work: and of object, as the one in which the interventions are done”¹⁸ (p. 71).

In turn, situations experienced in adolescence, such as progressive separation from parents, attachment to new groups, search for self and identity, fluctuations in mood, social attitude, as well as issues related to sexual initiation and other aspects of sexuality³⁹, for example, require integrally oriented teaching practices^{18,31,40}.

However, often, higher education courses offer a “package” of technical-scientific content to the detriment of the subjective production of care^{9,15,18}. In addition, students become passive interlocutors during training, and later, on entering the services they are caught by the clipped-reduced-corporate-centered axis¹⁵. One respondent exemplifies this approach to teaching, limited to biomedical issues and ignorant of the complexity of ethical-political dimensions surrounding adolescent health care:

I think it was good [the training], because the basic subjects that we work on are independent of the age group - physiology, anatomy, the functioning of the human body - have some peculiarities with age, but, for example, medicine will answer similarly, the elderly have a small change, you have to make a correction, with a child you have to be careful with the dose, but with regard to treatment and conduct, there is nothing more. I think it served well [the training], there is no why, today there is a specialty - *hebiatria*, which is aimed at this audience, but with regard to graduation, I think it was not insufficient. (P16 - Doctor)

In the opposite direction, several bets have been made towards changes in formation and ways of conceiving the production of interdisciplinary and multi-referential knowledge^{35,36}. These changes aim to bridge the gap between the biomedical conception, centered on social medicalization¹⁶, that guides hegemonic medical practice, and health practices guided by a dialectical conception in the production of health care⁹.

In this sense, it is important that the pedagogical process is reflexive and dynamic. However, the interviewed professionals pointed out that during the academic formative period, there were no experiences with active methodologies and that the adolescent health-related component was based on the transmission of contents, lacking problematization. Such issues show a poor production of health knowledge, especially when the topic is focused on vulnerable populations and/or those populations that are difficult to link to health services^{1,41}. In this sense, when the educational approach is vertical and focused on content accumulation, with scarce holistic and dialectical approaches to the adolescent health-disease process, there is ample possibility to train professionals focused on the biological core, suffering from limitations to propose creative and dialogical interventions, essentially due to the lack of prior references, resulting in highly medicalizing practices¹⁶. The fragments below summarize this perspective:

[...] The methodology used to teach the classes of the discipline of ‘child and adolescent health’ was the traditional one, it was not new. (P1 - Nurse)

In lectures, I used a traditional methodology, with slides and content exposure by the teacher. (P7 - Doctor)

Moreover, it is important to highlight that the proposals debated for the transformation of health courses involve the methodological character of teaching or didactic-pedagogical approaches techniques, however, they carry “culturalized” contents. In this way the traces of production and social reproduction remain, regardless of the didactic model⁴².



Continuing health education and adolescent invisibility

To understand these results, this category is based on the perceptions of professionals (FHS and NASF) and managers.

From the perspective of training workers involved with SUS, the National Policy of Permanent Education in Health⁴³ promoted the transformation of the educational model aimed at the development of actions directed to meaningful learning in daily work as a techno-political issue⁴⁴. Such a perspective involves changes in relationships, processes; health acts, organizations and people, thus requiring a myriad of synergistic training strategies⁴⁵.

However, the interviewees (managers and professionals) considered the in-service education activities insufficient, as they are not always implemented; and when they happen, they usually did not cover care with adolescents, as illustrated by the following excerpts:

We need more training to be able to help these teenagers. The nurse does whatever she can, she talks about vaccine, leprosy, tuberculosis, prenatal, breastfeeding, now about adolescent, since I am here there was none. (P3 - ACS)

Regarding continuing education, the municipality does not develop actions focused on this topic [adolescent health]. Regarding the other topics, they are developed even if not 100%. (P1 - Nurse)

NP5 (Psychologist) - We need the Ministry of Health to focus more on planning, courses for us from NASF, because they demand a lot from us as a professional, but they do not offer us this support. (GF - NASF)

NP6 (Nutritionist) - I think it is the most difficult public that has to deal with and is the one that offers the least qualification. (GF - NASF)

The management itself does not receive any course, qualification or training focused on adolescent health. Everything we do is our own initiative. (G3 - Nurse)

The reports reinforce the finding of collective mismatch in the production of adolescent health. Worryingly, managers in the role of institutional supporter and service organizer and NASF professionals in the matrix support role did not feel prepared to provide pedagogical support to PHC professionals within the scope of adolescent health. The actions appeared to be a result of individual motivation by some professionals without institutional support and without a support network. Nevertheless, despite some positive initiatives, the incorporation of systematic and institutionalized opportunities for continuing education for professionals is still scarce throughout the country⁴⁶.



Managers pointed out the formative deficiency of professionals as a reason for not approaching adolescent care in permanent education actions, leading them to prioritize themes related to already institutionalized programs, and adolescents going unnoticed in these educational activities. Moreover, they also report the turnover of professionals as a challenge for the implementation of permanent health education actions, hindering the continuity and advancement of the themes, due to the change in the staff that required the repetition of topics that were touched in previous moments.

Continuing education has decreased a lot. We seek suitable professionals to address a particular theme and we vary the themes, but no theme focused on adolescent health, unfortunately. [...] there is always a high turnover [of professionals], so when you think “now I talked about all the basic themes”, there are many changes and we go back to those common themes. [...] The adolescent’s non-approach in continuing education is due to lack of interest by management. (G1 - Nurse)

Despite the difficulty in the development and consolidation of permanent health education as a result of the precariousness of employment relationships and the consequent turnover of professionals, it is understood that, by qualifying the professional for health work, permanent education contributes to the appreciation of the workers, favoring retention.

According to managers and health professionals, topics were being surveyed within health teams so that in-service education activities were congruent with the demands of professionals:

Right now, we are doing some research because there are several capabilities. So, we are seeing what the need is, we gathered with them “oh, you need training,” but training in which area? Who is it for? What audience? (G5 - Administrator)

They are starting. They even asked each professional to deliver until next week a training suggestion that he would like to have, I even asked about syndromic approach, because of the sexual health complaints, which are many here, which does not leave the teenager out, but I don’t remember anything exclusive for adolescents. (P10 - Nurse)

In this sense, although adolescent care is not listed among the themes for educational actions, the method used to define such themes approached the precepts governing permanent health education, as it tried to articulate the construction of proposals encompassing the needs of the subjects. In this context, for educational actions to take into account the need for services, it is necessary that professionals and managers, immersed in the daily life and complexity of their problems, may read reality using theoretical contributions or lenses that broaden the critical look, so that the educational actions are fruitful and can effectively impact the resignification and restructuring of the work process^{44,47}.



Given the lack of face-to-face in-service education activities, technological tools, such as telehealth, were cited by respondents (professionals and managers) as important facilitators of access to this type of training:

Today we have a lot of distance learning, such as the Tele-health portal that brought various themes, with lectures. The government has invested a lot in it. I believe that we as workers should plan a way to watch these courses, set aside on our agenda a moment, for that too. But this is more a weakness of the organization of the work process than of a public policy. Because those courses are there, we have eight computers inside the unit with internet access. We do not have a multimedia data-show that would make it easier for all professionals. (P2 - Dental Surgeon)

Unfortunately our training is scarce. Nowadays we have more chances because there are online activities that we may access if it's in our interest. But regarding PHC specifically, to its promotion just a few were developed. (P14 - ACS)

Regarding continuing education, we do whatever we can to do, we were even a little stopped [the education activities in service], but we come back now. Actually, professionals have telehealth in the units. (G2 - Nurse)

The discourses show clearly that information technologies were valuable instruments in the improvement and updating of health workers. In this sense, the National Telehealth Brazil Program has been used at PHC as a means for continuing education at PHC⁴⁸. In addition to training, professionals who participate in telehealth activities have the possibility to build their own knowledge, through the exchange of experiences with professionals from other regions, who experience a different reality in performing the same activity⁴⁹. This contact with other realities favors the broadening of glances in the qualification of care and the implementation of changes in the work process. In addition, issues related to adolescent health have been addressed in videoconferences^{48,49} thus favoring the training of PHC professionals.

However, as pointed out by the interlocutors of this study, the use of this distance education resource by health professionals depends on their personal initiative, on resources such as computer and internet, as well as a better organization of the work process to allow a space in the workplace schedule for such activity. These aspects are obstacles that need to be overcome in order to achieve the desired goal in distance education activities⁵⁰.

Regardless of the use or not of informational devices, permanent health education has as its central element the transformation of professional practices and the work organization itself, through the introduction of mechanisms, spaces and themes that generate self-analysis, implication, self-management, institutional change, thought (disruption with established formulas or models) and experimentation²⁹.



Likewise, by placing the professional on the agenda of analysis, by permeating the concrete relationships that operate realities, permanent health education enables the construction of fertile collective spaces for the reflection and evaluation of meanings of daily produced acts⁴⁴.

Moreover, professionals are often captured by the way health care is reproduced and do not reflect on the care provided to adolescents in their daily practice, perpetuating inadequacies in the way health is performed.

I think we also accommodate a little. I took a tour in the PSF, I did not want to change the pace of the PSF, so [...] Since before, I have not seen a program aimed at the teenager. (P13 - Nurse)

Therefore, permanent health education becomes a fertile ground for breaking this alienation of neglected adolescent care, based on meaningful and meaningful learning, which makes the subject question what is posed, thus creating the possibility of transformation of the care produced in their work process.

From this point of view, formal knowledge must enable the self-analysis and self-management of the collectives, as the everyday subjects, agents and agencies are those who must lead the change in reality aimed by educational practices⁴⁴.

Professional unpreparedness and adolescent perception

To understand these results, this category is based on the perceptions of groups with adolescents in territories covered by the Family Health Strategy.

The lack of preparation of professionals, both in the technical and relational dimension, was denounced by adolescents as an obstacle to the adherence to the proposed actions, as well as to the establishment of the professional-user bond.

A6 – To have a good bond, the professional has to be ethical; A7 - Have to pass security; A6 - I do not want to speak ill of anyone, but I think so, many good doctors have been here, but I think the current one is not that good. He does not pass a safety sense, a professional has to pass a sense of safety to the patient and he does not pass because he is reading in the book or searching the cell phone in front of us. A7 - That! A6 - I think he is crazy; he has no chance. So on the part of the doctor I don't think he's a good professional, a quality professional; A2- For a good bond, you have to be nice; A3- Be sincere; A1 - have education and give confidence [...] A5 - The professional who works with adolescents has to do different activities, some legal dynamics [...] Because there are people who are only in the lecture, it is very annoying to have to watch the slide; A6 - The professional has to be creative, persistent, has to know how to move with a teenager, so that the teenager comes to participate in these things. (GF-2 adolescents - urban area)



A11 – Teen care should be better in everything; A4 - Some services are terrible, there are people who are not competent; A3 - truth; A9 - I don't even want to come. (GF-3 teenagers - rural area)

A7 – For a good consultation, the professional has to know how to deal with the problem, know how to help you if you have any questions and explain things right. [...] In group activities, the professional who guides them has to be fun, they have to know how to get the adolescent's attention so that they can come; [...] A4 - Many times, those who are up front, they start talking, talking, and teenagers start to get bored and talk and don't understand anything and end up not solving anything. (GF4 teenagers - urban area)

Thus, despite being characterized as a lightweight technology⁵¹, the adolescents' discourse showed that the bond proved to be dependent on structured knowledge, that is, on light-hard technology⁵¹, because trust in the professional was conditioned to the knowledge shown in the act. Thus, the bond is not restricted to good professional-user interaction, but also requires good assistance in face of the problems manifested by users in the effective production of expected and necessary results, thus, credibility in the service will be achieved⁵².

The proper preparation of the professional in adolescent care becomes essential not only in the implementation of actions at the individual level, but also at the collective level, because in order to be able to link the adolescent to the activities, they must be interesting and attractive, requiring professional communication skills, confidence, creativity, and the ability to captivate, instigate and hold attention.

However, such requirements are challenging, since inadequate training of professionals is one of the central problems, weakening the performance of educational actions in the logic of popular health education⁵³, frequent vertical and imposing approaches that do not favor the leading role and empowerment of the subjects⁵⁴.

Conclusion

The permanent formative process of managers and health professionals for the production of adolescent care in PHC was unveiled confronting the conservative teaching model, centered on intervention practices and focused on social medicalization. In addition, even newer continuing education strategies such as the COAPES (Organizational Contracts for Public Action Teaching-Health) have encountered resistance because of scarce traditions in intersectoral articulation.

To overcome the status quo related to the hegemonic mode of care production and consequent adolescent invisibility in health services, there is a need of a greater investment in the teaching-learning process of future professionals through curricular matrices, taking into account the multi-referentiality.



In addition, the subjects must continually establish the dialogue between educational institutions, health services and the community, especially, listening to the biggest interests - the adolescents.

Finally, the rationale for PHC should be territorial care, which means changing the biomedical logic that is insistently trying to get adolescents into the FHU (as consumers of procedures), but instead encouraging the team to meet the community, and therefore meeting with the adolescents and young people in the territory. In this sense the main issue is not to make a FHU more attractive, but to make health actions more coherent and appropriate to the needs / lifestyles of adolescents, from the perspective of comprehensiveness of health.

Authors' Contributions

ESF Fernandes participated in the conception and design of the work, carried out the fieldwork, analyzed the results, wrote the manuscript and approved the final version. AM dos Santos oriented the research (Professional Master in Public Health), conducted a critical review of the content and approved the final version of the article.

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Objetivou-se discutir aspectos relacionados ao processo formativo de gestores e profissionais da Atenção Básica à Saúde (ABS) no cuidado à saúde do adolescente. Trata-se de pesquisa qualitativa com participação de sete gestores e 17 profissionais da ABS em entrevistas semiestruturadas, dez profissionais do Núcleo de Apoio à Saúde da Família e 47 adolescentes em grupos focais. A análise foi ancorada na perspectiva hermenêutica-dialética e utilizou o conceito de cuidado integral para balizar o debate teórico. Profissionais e gestores consideram a graduação e a educação permanente incipientes, não abarcando o cuidado integral. O despreparo do profissional foi destacado pelos adolescentes como entrave para vinculação ao serviço. É necessário maior investimento na formação/capacitação dos profissionais como caminho para aperfeiçoar a prática nos serviços da ABS, a fim de torná-los mais coerentes e adequados à lógica de cuidado e às necessidades e aos modos de vida dos adolescentes.

Palavras-chave: Saúde do adolescente. Atenção primária à saúde. Saúde pública. Educação superior. Educação permanente.

El objetivo del estudio fue discutir aspectos relacionados con el proceso formativo de gestores y profesionales de la Atención Básica de la Salud (ABS) en el cuidado a la salud del adolescente. Se trata de una encuesta cualitativa con participación de siete gestores y 17 profesionales de la ABS (entrevistas semiestruturadas), diez profesionales del Núcleo de Apoyo a la Salud de la Familia y 47 adolescentes (grupos focales). El análisis tuvo como ancla la perspectiva hermenéutica-dialéctica y utilizó el concepto de cuidado integral para delimitar el debate teórico. Profesionales y gestores consideran la graduación y la educación permanente incipiente, no incluyendo el cuidado integral. La falta de preparación del profesional fue subrayada por los adolescentes como obstáculo para el vínculo con el servicio. Es necesaria una mayor inversión en la formación/capacitación de los profesionales como camino para perfeccionar la práctica en los servicios de la ABS, con la finalidad de hacerlos más coherentes y adecuados a la lógica de cuidado y a las necesidades/modos de vida de los adolescentes.

Palabras clave: Salud del adolescente. Atención primaria de la salud. Salud pública. Educación superior. Educación permanente.

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