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Competences in health promotion: conformations and resources mobilized in the multiprofissional residency

Competências em promoção da saúde: conformações e recursos mobilizados na residência multiprofissional

Competencias en promoción de la salud: conformaciones y recursos movilizados en la residencia multiprofesional

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Abstract

Objective: to recognize the conformation of competences in health promotion in the multidisciplinary health residency. **Method**: a qualitative study, carried out with multiprofessional residency programs in the state of Ceará and guided by the Competences in Health Promotion Project (CompHP) framework. Thirteen professionals from the faculty of five residency programs with priority performance in primary care took part. The data were collected through semi-structured interviews and interpreted using a dendrogram organized in ALCESTE. **Results**: two classes were originated relating the conceptions of the residency faculty collegiate about competences, competence in health promotion and its development from the training process of the multidisciplinary residency. The development of skills in health promotion in the multiprofessional residency involves the articulation of psychomotor, cognitive and affective attributes. Therefore, collective and multidisciplinary practices are valued, using communication strategies, popular education and identification of partnerships, among others. **Final considerations and implications for the practice**: fostering the development of skills in health promotion contributes to overcoming traditional teaching models and health practices; however, political, institutional and social aspects highlight the need for caution in the development of studies based on training of multidisciplinary teams, representing study limitations.

Keywords: Health Human Resource Training; Professional Competence; Competency-Based Education; Internship, nonmedical; Health Promotion.

Resumo

Objetivo: reconhecer a conformação de competências em promoção da saúde na residência multiprofissional em saúde. **Método:** estudo qualitativo, realizado junto aos programas de residência multiprofissional do estado do Ceará e orientado pelo referencial do *Competences in Health Promotion Project* (CompHP). Participaram 13 profissionais do colegiado docente de cinco programas de residência com atuação prioritária na atenção básica. Os dados foram coletados por meio de entrevistas semiestruturadas e interpretados por meio de dendrograma organizado no ALCESTE. **Resultados:** duas classes foram originadas relacionando as concepções do colegiado docente da residência sobre competências, competência em promoção da saúde e seu desenvolvimento a partir do processo formativo da residência multiprofissional. O desenvolvimento de competências em promoção da saúde na residência multiprofissional envolve a articulação de atributos psicomotores, cognitivos e afetivos. Para tanto, valorizam-se as práticas coletivas e multiprofissionais, utilizando estratégias de comunicação, educação popular e identificação de parcerias, entre outros. **Considerações finais e implicações para a prática:** fomentar o desenvolvimento de competências em promoção da saúde contribui com a superação de modelos tradicionais de ensino e práticas de saúde, entretanto aspectos políticos, institucionais e sociais destacam a necessidade de cautela no desenvolvimento de estudos pautados na formação de equipes multiprofissionais, representando limitações do estudo.

Palavras-chave: Capacitação de Recursos Humanos em Saúde; Competência Profissional; Educação Baseada em Competências; Internato não Médico; Promoção da Saúde.

Resumen

Objetivo: reconocer la conformación de competencias en promoción de la salud en la residencia multidisciplinaria de salud. **Método**: estudio cualitativo, realizado con programas de residencia multiprofesional en el estado de Ceará y guiado por el marco del Proyecto de Competencias en Promoción de la Salud (*Competences in Health Promotion Project*-CompHP). Participaron trece profesionales del cuerpo docente de cinco programas de residencia con actuación prioritaria en atención primaria. Los datos fueron recolectados a través de entrevistas semiestructuradas e interpretados mediante un dendrograma organizado en ALCESTE. **Resultados**: se originaron dos clases relacionando las concepciones del cuerpo docente de residencia sobre competencias, competencia en promoción de la salud y su desarrollo a partir del proceso formativo de la residencia multidisciplinaria. El desarrollo de habilidades en promoción de la salud en la residencia multiprofesional implica la articulación de atributos psicomotores, cognitivos y afectivos. Por ello, se valoran las prácticas colectivas y multidisciplinarias, con la utilización de estrategias de comunicación, educación popular e identificación de alianzas, entre otras. **Consideraciones finales e implicaciones para la práctica**: fomentar el desarrollo de habilidades en promoción de la salud contribuye a superar los modelos tradicionales de enseñanza y prácticas de salud, sin embargo aspectos políticos, institucionales y sociales resaltan la necesidad de cautela en el desarrollo de estudios basados en la formación de equipos multidisciplinarios, configurándose como limitaciones de este estudio.

Palabras-clave: Capacitación de Recursos Humanos en Salud; Competencia Profesional; Educación Basada en Competencias; Internado no Médico; Promoción de la Salud.

INTRODUCTION

Despite the constant ideological, political, economic and social retrograde threats of today's manifestation in society, the consolidation of the Unified Health System (*Sistema* Único *de Saúde*, SUS) is based on the factual proof of its beneficial and resolving effects on well-being, quality of life and health promotion for Brazilians.

Acting effectively in health promotion requires the synergistic articulation of knowledge, skills and attitudes consistent with the reality and health demands of the population.[1] For this, the professional practice must take place from actions that involve, among other requirements, autonomy, ethics, and ability to diagnose and solve problems within the scope of care and health care management.[2]

Considering the complexity of the political and practical alignment of health care, over the last 30 years, many debates have been raised about the professional skills needed for this. Therefore, these discussions involve the training processes and the locus of learning in health.[2]

In this context, the multidisciplinary residency in health presents itself as an important scenario, whose dynamics of the training process offers significant potential for the development of skills in health promotion with social actors such as residents, preceptors, tutors and professionals of articulated health services in its composition.[3]

The multidisciplinary residency fosters the training of human resources in health based on permanent education and competence-based education, which seeks to replace the biological logic with a way of thinking and knowing capable of apprehending objects in their context and complexity, integrating knowledge, being supported on the extended clinic, therapeutic project, interdisciplinary and multiprofessional work.[4]

These aspects are consistent with the professional requirements proposed for working in health promotion of the *Competences in Health Promotion Project* (CompHP). CompHP brings together a set of essential competences for an effective practice in health promotion, formulated from multivariate exchanges of knowledge from international experts and extensive literature review, materializing as a reference for practices, education and training for health promotion.[1]

The set of essential competences proposed by CompHP to develop effective actions in health promotion encompasses values, knowledge, skills and attitudes, listed in 47 competences grouped into nine domains, namely: 1) Favoring changes; 2) Advocacy in health; 3) Partnership; 4) Communication; 5) Leadership; 6) Diagnosis; 7) Planning; 8) Implementation; and 9) Evaluation and Research.[5]

It is from the consolidation of these professional competences that the resident, as a SUS worker, will favor a professional committed to transforming the health practices, promoting innovations and providing qualified and integrated care and management.[6] Therefore, the question is: How are the competences in health promotion understood in the training of the multidisciplinary residency in health? What resources are mobilized for their development in this training?

From this perspective, the objective was to recognize the conformation of competences in health promotion in the multidisciplinary health residency.

METHOD

An exploratory study with a qualitative approach, carried out with the Multiprofessional Residency in Health programs in the state of Ceará and anchored in the *Competences in Health Promotion Project* (CompHP), as a theoretical framework.

The choice of Ceará as the milestone scenario for this study is justified by its contribution to the training of health professionals and to the advancement of public health policies, contemplating one of the pioneer programs in the residency modality in the context of family health, as well as the program with highest number of vacancies per class in the country, with territorial distribution in all the of the state's health macro-regions.

In this context, and appreciating *a priori* the multidisciplinary residency programs with essential action locus in primary care, the totality of programs active for at least three months was considered, namely: two programs with a training institution in the municipality of Sobral and three programs with a training institution in the municipality of Fortaleza. It is to be noted that, during the process of carrying out this study, a new residency program started its activities in the municipality of Crato, although it did not comprise the participating sample considering its initial implementation character.

The population of interest consisted of professionals engaged in the pedagogical conduct of non-medical internship programs of the multiprofessional health residency type, such as general coordination, coordination of emphases and tutors, who were invited to take part in the study, from an intentional sample that was non-probabilistic, and those who met the eligibility criteria: being linked to the training institution responsible for the residency and acting directly in the faculty for at least three months, this period being estimated to be sufficient to take part in the planning and/or execution of the pedagogical activities relevant to health promotion and development of competences. The exclusion criterion was as follows: being away from their activities, for any reason, during the data collection period.

In Institution A, 12 professionals met the inclusion criteria and seven took part in the study. In Institution B, of the 11 eligible professionals, six took part in the study. Thus, 13 professionals were delineated as the sample.

As the technique for data collection, interviews were conducted with key informants, guided by a semi-structured script that included questions about the conceptions of health promotion in the training process and its materialization in theoretical and/or practical moments.

Upon approaching the study setting, the names and contacts of the key informants were surveyed. Subsequently, the interviews were scheduled by means of telephone calls, which took place at an appropriate time, condition and location, according to the

participants' availability. Upon completion, after reading and signing the consent form, the speeches were recorded in digital audio, for greater accuracy of the information, with a mean length of 45 minutes each.

In order to guarantee reliability of the information and greater data consistency, when transcribing the speeches in *Microsoft Word* 2013®, they were returned to the participants for reading and confirmation and/or complementarity of the ideas regarding their narrative reliability, taking into account the *member check* technique. Subsequently, such material subsidized the elaboration of the analysis *corpus*, in Richtext format, called CompRMS and processed by the *Lexicale Analysis by Context of an Esemble of Text Segments* (ALCESTE) software, version 2015®.

Among the interpretive possibilities of data from the perspective of lexical analysis, it was decided to interpret through the perspective of content, naming and interpreting each class from the information provided by the software regarding categories. The results presented by ALCESTE refer to the representation of the Elementary Context Units (ECUs), which consist of text fragments with complete meaning, in classes, based on the interrelationship between the words, the ECUs and the classes themselves. In their processing, full words are also highlighted as representative of the ECUs that comprise a class, and these words exceed the meanings recorded in dictionaries, as they are influenced by the participants' insertion context, characterizing their field of reference and discourse.

The classes originated by ALCESTE are presented by means of a descending dendrogram. They express the words that are closest to each other due to their symbolic content and, thus, represent the nuclei of meaning of the information collected and supported the analysis in the light of the framework adopted and the pertinent literature.

There was concern about meeting the ethical aspects of scientific research with human beings, with the study being authorized after consideration and approval by the Research Ethics Committee of the Regional University of Cariri, according to opinion No. 1,973,784. In order to guarantee and ensure confidentiality of the information, codings were assigned through the abbreviation "Part" followed by the participation number.

RESULTS

Thirteen professionals took part in the study, of which two were coordinators and eleven were tutors. Most of the participants were female (eleven interviewees). The mean age of the participants was 36.8 years old, and the performance time varied from eight months to 11 years, with a mean of three years and six months in activities related to the multiprofessional residency.

The current position of tutoring or coordination makes up a minimum period of three months and a maximum of seven years. It is noteworthy that, for eight of these professionals, the teaching experience takes place upon insertion in the multiprofessional residency.

Regarding the training of these professionals, variation was verified between the professional centers, marked by the presence of professionals from the humanities and health sciences, as follows: four nurses, two physical education professionals, two social workers, two psychologists, a dentist, a physiotherapist and a historian. In relation to the graduate education of these professionals, the highest degree observed is that of Master, corresponding to the titration of eight of the interviewees, followed by the degree of Specialist, for five participants.

Processing of the interviews in ALCESTE gave rise to the dendrogram and, considering the principle of independence between distinct branches and intimate connection between the classes of the same branch, as well as the forms/full words of each segment of the *corpus* and ECU, the classes were classified into two blocks, the block entitled "Competences in health promotion in the context of the multiprofessional residency in health" being of interest, herein presented the study objective.

The "Competences in health promotion in the context of multiprofessional residency in health" block comprises two classes, composed of 86 ECUs, which relate the conceptions of the collegiate professor of the residency about competences, competence in health promotion and its development from the training process of multiprofessional residency.

In an illustrative manner, the classes in question are represented in the dendrogram (Figure 1), along with the reduced forms representative of the class and the strength of each shape in the middle of the class, figured by chi-square ($\chi 2$).

Competences in Health Promotion: Conformations in The Multiprofessional Residency in Health

This category groups the conformations of competence in health promotion in the context of the residency training, based on the conception of competence as an articulation of knowledge, skills and attitudes for an effective practice. In this context, they represent the following dimensions: cognitive (knowledge), psychomotor (know how to do) and affective (know how to be).

The lexical analysis of ALCESTE showed the prevalence of knowledge (χ^2=80), followed by skill (χ^2=50) and, finally, by attitude (χ^2=44). This sequence shows that there is still overvaluation of knowledge about skills and attitudes.

The study participants pointed out the following:

> *A competence for me would be the union, the combination, between theoretical and natural knowledge, about the theme, allied to the skills, when the resident can precisely perform such construction of what is recommended by the literature, say, that ability to deal with a given situation.* (Part05).

> *So the competences that we work on, within this field of the residency, is you have knowledge, skills and attitudes towards a given theme.* (Part08).

In this context, the conception of attitude is related to the relational competences, such as loveliness, which situate the being in a social environment and require it to take postures in the face of different situations.

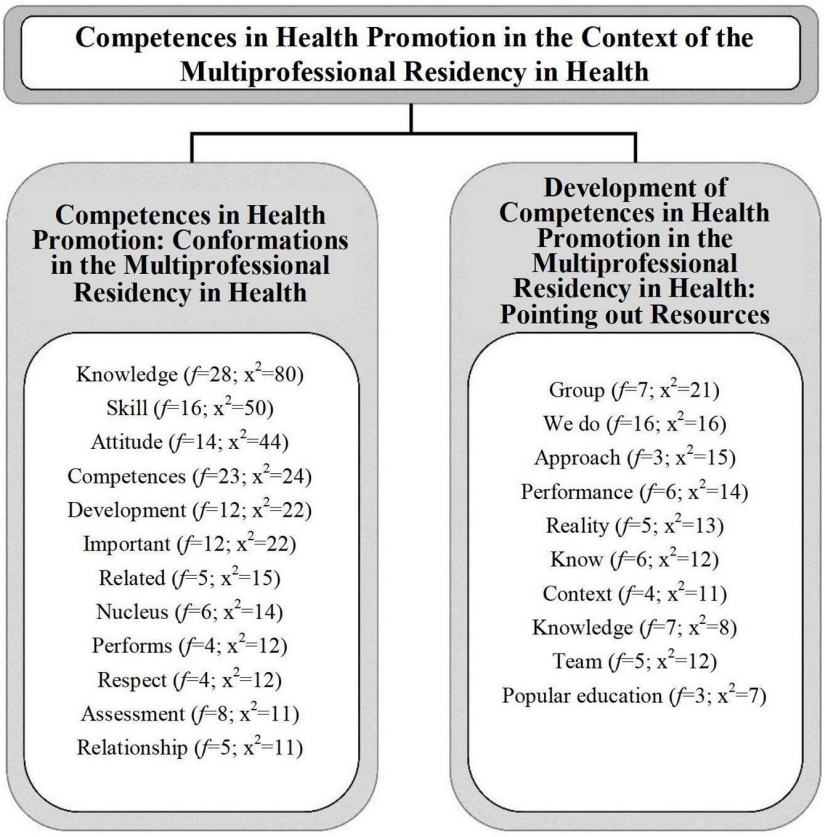

Figure 1. Ascending classification dendrogram of the "Competences in health promotion in the context of the multiprofessional residency in health" block. Crato, 2017.

> *We realized that relational skills, which we call transversal, such as loveliness that is a competence that we put, which is to develop during the two years, so it is in all the cycles, it is transversal. But we realize that it is still a thing of the person, the person to gradually understand, transform.* (Part01)

Skills and attitudes gain space in the training process of the multiprofessional residency, mainly due to the workload devoted to practices and experiences in the territory, which promote the encounter with other professionals, individuals, families and community, thus exercising interpersonal interactions and development of actions.

In such journey, progress of the competences in the residency coincides with the overcoming of remaining gaps in the graduation of health professionals and related areas belonging to the training process, sometimes originated due to the rapid conduction of training and to the predominance of traditional teaching-learning methods.

> *The competence from the educational perspective she has been seeking and looking from the construction of three pillars that are important, which are knowledge, skills and attitudes. So, in the residency it is different from other backgrounds, from other courses, which often focus a lot on the issue of knowledge.* (Part11)

In this process, the challenge arises to evaluate the resident professionals' performance in the face of knowledge acquisition, expansion and improvement of skills and, mainly, the improvement of attitudes, as shown in the following statements:

> *We have more security in evaluating macro-competencies, but those of the core* (professional core of each category) *we are still crawling and trying.* (Part10)

> *So our dimension of the competence that we work on, it will relate to each cycle, [...] that part of such competence is a part that requires a lot of people to evaluate.* (Part01)

Thus, since its conception, the multiprofessional residency programs under study are concerned with the development of competences and their targeting for health promotion.

Development of Competences in Health Promotion in the Multiprofessional Residency in Health: Pointing out resources

This category brings together resources pointed out by the participating professionals as essential to enable the development of competences in health promotion in the multiprofessional residency, namely: strengthening of groups, popular education,

knowledge of the territory, adequate communication, work flexibility, and systematic organization of the health promotion actions.

Strengthening of groups concerns the appreciation of collective practices, mainly through the implementation of groups, either by creating them or by reinforcing and improving those already existing in the territory. Therefore, it is necessary to anchor in the knowledge of popular education, which considers subjects as protagonists of their own learning process and, thus, of producing care and health, as exemplified by the participants:

> *Then there is exchange of knowledge itself. Exchange of knowledge that we need to have with the professionals, with the community.* (Part02)

> *Within popular education, which we work hard, each one is trying to collaborate with the other, according to what we already know or experienced. Trying to make that switch. And we are only doing this mediation, in these groups.* (Part04)

The effectiveness of the groups is also related to the use of appropriate techniques and technologies for communicating the health promotion actions, encompassing verbal communication, correct and contextualized use of language, and dynamic observation of the context through nonverbal communication.

> *Another thing he needs to have as competence is adequacy of what he needs to work in a population, or the level of understanding, the users' language, to just get there in the territory and talk about diabetic foot, in a group of hypertensive and diabetic people and not use a purely technical approach.* (Part05).

Performance based on the recognition of the needs and offers of the territory is also pointed out, identifying key actors, partner devices and structuring a work process focused on territorial logic and healthy practices.

> *I need to know for me to act. I need to know what context this is that I am experiencing.* (Part02)

> *Going to do some community action? You need to know, what territory, what population, what is common, how to approach.* (Part06)

Performance focused on health promotion, finally, requires the abandonment of prescriptive and plastered practices towards a dynamic and flexible work process that allows inventing and reinventing itself in the face of the possibilities and needs of a territory that is alive and of a population with complex demands, as presented below:

> *I need to know, know and renew my work all the time. I need to review, I need to evaluate and I need to modify.* (Part06)

DISCUSSION

In the context under analysis, overvaluation of the knowledge about skills and attitudes is recognized. This conception of competences, with emphasis on knowledge, consistent with a historical-cultural process that permeates the educational processes since the Middle Ages, is a reflection of the positivist, biologicist and medical-centered character still sustained by the training process.

The literature shows that, in the development of competences in health promotion, not distant from traditional education, dominance of scientific knowledge is also noticeable, occupying a hierarchical position privileged to skills and attitudes, while it also expresses concern in transforming that reality.[7]

Although there is greater appreciation of the knowledge dimension, some statements express that the competences refer to an articulation of aspects that involve knowledge, know-how-to-do and know-how-to-be. This logic is close to the assumptions of the CompHP about the definition of competences, establishing them as essential requirements for professional performance.[1-2]

The conformation of the training process in the residency places professionals in the community bulge, so that, from the understanding of reality and the establishment of bonds with the users of the health service, the professionals can develop actions that improve their living conditions and health.

Therefore, a cyclical, two-dimensional and mutual collaboration process is envisaged, where professional contributions to the care of the individual, family and/or community reinforce and improve the very development of this practice.[3] Thus, the care object of the health professionals is also the transforming axis of their professional practice.

The development of competences in health promotion, especially in the scope of primary care, requires the effective mobilization of attitudinal and psychomotor processes, since the complexity experienced in this scenario requires the professionals to have more than knowledge, contemplating ethical values and social responsibility before the community, as well as the development of skills and attitudes.[8]

The development, improvement and strengthening of these competences requires exposure of the residents to singular situations in which they can act technologically with the social reality and dialog with it, approximation with the reality of the services being the ideal opportunity to reach this relational object. This reasserts that progress in the competences coincides with overcoming gaps left by training in the traditional model.[9]

The porosities perceived in professional training at the undergraduate level, even in the face of advances in discussions in the field of education, are partially due to the freedom that higher education institutions enjoy in organizing their courses, where, supported by the Law of National Education Guidelines and Bases (*Lei de Diretrizes e Bases*, LDB), they organize the training processes for the preparation, almost exclusively, for the labor market, perpetuating a model of flexerian, biomedical and curative training.[10]

The current policies and assumptions of permanent education in health indicate that the training of these professionals should stimulate the discovery of new and diverse ways of acting in health promotion, directed by the principles of the SUS, with a view to producing relevant knowledge for the provision of care, integrating health education and production, establishing cooperation between health and education to qualify management, and fixing professionals in the public health system networks.[10]

However, there is recognition of the advances already provided by the implementation of these guidelines that defend the training of professionals concerned with the collective, engaged in developing promotion, prevention, recovery and rehabilitation actions, from the perspective of integrality of care, in addition to the design and execution of flexible curricula directed to the acquisition of professional competences through the use of modern learning methodologies applied in multiple teaching scenarios.[10-11]

Among the changes already noticeable is the promotion of "processes of learning to be, to live together and to know, training professionals with autonomy and ability to ensure comprehensive and quality health care".[11:234] Recognizing and valuing the development of competences in the multiprofessional residency is a foundation for training in health promotion because it corroborates the expansion of professional standards and quality assurance systems that confirm health promotion as a specialized field of practices.[12]

The competence-based approach comprises in a logical and sequential way the specification of the problems to be addressed; with those that emerge from the territory and professional practice, identification of the necessary skills, adaptation of the curriculum to achieve skills, and evaluation of achievements and recognition of gaps being preferable.[2]

Regarding the evaluation of these competences, delineated as a challenge by the participants, it is necessary to think about instruments that group the knowledge, skills and attitudes that make up the desired competencies and how they manifest themselves in the daily activities of the training processes, so that an objective follow-up can be carried out.

In this perspective, CompHP, to the extent in which describes the specific competences for each domain, both contributes to the direction of the training process, as well as it allows for a better monitoring of their development.[13]

There are several existing strategies to monitor the development of competences. One of these strategies, appropriate to ascertain whether an educational proposal was able to promote the development of the competences profile proposed, is to compare the initial perceptions of the professionals participating in the training with the results at the end of the course.[14] In this case, it is not a performance assessment, but the perception of residents about their mastery of the underlying capabilities to performance.

In the reality under study, something similar also happens in the evaluation process of residents, which, by means of a dialogical assessment throughout the training process, considers the consensus of perceptions of the evaluated resident and their preceptors, as well as of the service professionals.

The evaluative proposal is then based on contemplating different perspectives and outlooks on professional adequacy, breaking the barriers of care centralization, thus fostering the articulation of knowledge and practices in an inter- and trans-disciplinary perspective.

With regard to the resources mobilized to develop these competences, the group activities implemented in the context of the health services have manifested themselves as one of the main strategies developed. As expressed in the statements, they present a connotation of education in health, based on the dialogical model of popular education.

This model presents characteristics that are common to the health promotion movement when thinking about the reality of the individuals and the environment in which they are inserted, by valuing and encouraging collective practices. This is a key element to organize changes in the quality of life and health of the subjects involved.

Contemplating popular education, education in health exercises its educational character bilaterally, where both parties involved learn by means of a relationship that promotes exchange of knowledge. Thus, group activities are characterized as a democratic and solidarity process.[15]

Under such perspective, the correct and appropriate use of communication is fundamental to enable humanistic care and focused on the health needs of the subjects, as it ensures the interaction between health professionals and users, families and the community, not only from a relationship of care, but from sensitivity, acceptance, empathy and exchange of knowledge.[16]

In the territory, I herein specify the context of the action of primary care, and it is required that the subjects appropriate themselves on these manifestations, considering the subjectivities, the imaginary and the potential of the place to recognize the needs, key actors and partnerships for the development of actions.[17]

In addition to physical characteristics such as spatial delimitation, comprising all the social construction that occurred in it and that gave rise to it, the territories of action then present historical, demographic, epidemiological, administrative, technological, political, social, cultural and environmental aspects making it alive, in constant construction.[17]

For an effective performance in the health promotion field, it is believed that it is necessary that training sensitizes the professional as to the criticality of the aspects that mobilize health, constantly reflecting on the actions developed and how they can be improved and be appropriate to the realities.

The work process dynamics in health promotion, capable of transforming and positively modifying living and health conditions, only becomes possible through critical professionals with the ability to be flexible to the different contexts with systematic organization of actions to abandon prescriptive practices to meet the dynamic, flexible and reinvented model.[10]

It is resented that the training process experienced in the multiprofessional residency in health has aspects that are

consistent with the guiding proposals defined by the CompHP, while it evidences significant theoretical and practical approaches to this reference, indicating that the paths taken seek to focus on the training of health promoters, based on the development of essential competences, with communication, diagnosis of the demands and realities experienced, implementation and continuous evaluation of these actions among them.[1]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR THE PRACTICE

Considering the above, it is found that the competences in health promotion in the multiprofessional residency are understood as the synergistic articulation of psychomotor, cognitive and affective attributes that contribute to overcoming traditional teaching models and health practices. In this context, skills and attitudes are recognized and valued in the mutual association with knowledge, still identified as a centralizing and ordering dimension of the teaching-learning process.

In relation to the resources mobilized to this end, it is observed that, in the community component of the multiprofessional residency, there is appreciation of collective practices, reasserting the protagonism of those involved in the training processes implemented in primary care, since exchange of knowledge, use of appropriate communication strategies, popular education, recognition of the needs of the territory and identification of partners for actions focused on dynamism, flexibility and reinvention of health practices are opportune.

However, it is acknowledged that there are several factors, including political, institutional and social, which highlight the need for caution in the development of studies whose essence is based on the training of multidisciplinary teams, which can be delineated from the realities and locoregional demands.

It is necessary to emphasize that, to the extent that this premise manifests itself as a limitation of this study, it signals possibilities for the development of research studies that can investigate in depth the challenges herein indicated. It is also pointed out that, although the researchers performed narrative validation with the key informants of their transcribed statements, the impossibility of interpretive evaluation can also be pointed out as a limitation of this study.

Thus, essential elements for the development of competences in health promotion in the multiprofessional residency in health are herein delineated, enhancing the pedagogical process and planning of training moments concerning the advancement of health promotion practices, highlighting the need to consider the particularities of the territory and its actors and starting from a dialogical and participatory teaching and learning model.

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Data acquisition. Lucas Dias Soares Machado.

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