Knowledge and practices of dentistry undergraduates on health education required by the Unified Health System (SUS)

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ABSTRACT

The aim was to analyze the knowledge and practices of dentistry undergraduates on health education required by the Unified Health System, in addition to characterize the sociodemographic profile of these undergraduate students and identify their perspectives for professional practice. A descriptive study was carried out with a sample of 60 students enrolled in the last period of 2020 at the Federal University of Pernambuco. A semi-structured questionnaire was used in an online format on the GoogleForms platform and 49 students (81.6%) participated in the study. Most students want to work as a specialist (53.1%). Less than half (46.9%) claimed to know the training objectives of the course, but 87.8% considered that the health education contents are more developed in subjects of training axes 1 - health, humanistic and social training and 3 - health and dental sciences (65.3%). The understanding of health education related to the promotion and prevention of diseases predominated (57.1%) and as an act of transmitting/informing/guiding (46.9%), pedagogical strategies for educational actions/practices of transmissive disciplines (91.8 %) and the preference of using educational resources for lectures (59.1%). Regarding the aims of health education, making people aware of the importance of oral health (93.9%) and training for autonomy (73.5%) were prevalent responses. The majority considered self-care (71.4%), instruction/prevention of oral diseases (65.3%) and those based on transdisciplinarity (57.1%) as educational strategies aimed at primary health care. Incorporating health education into professional work was considered very important (89.8%). It was concluded that the understanding of health education is strongly linked to the positivist concept of a transmissive character, but expanded understanding of a participatory and popular character was observed.

Descriptors: Health Education. Oral Health. Learning in Dentistry. Unified Health System. Primary Health Care.

1 INTRODUCTION

In Brazil, more recently, a series of policies and strategies have been formulated to health workers in relation to the national health reality, with a view to strengthening the health care network of the Unified Health System (SUS). Among these policies, the National Curriculum Guidelines (DCN) for undergraduate health courses are highlighted, which propose the promotion of organic relations between the world of academia and the world of work at SUS[1].

For undergraduate Dentistry education, the impact of these policies induced curricular restructuration, which is being carried out in accordance with DCN[2] to establish contextualized training capable of facing the socio-epidemiological profile of prevalent oral problems. These changes demand from the faculty the challenge of reviewing the concept of health care with the adoption of the health promotion paradigm and not just focused on the care aspects of the disease[3,4].

These reform movements in health education occur in conjunction with other institutional actions to promote the reorganization of Primary Health Care (AB) in the country, as an imperative for the consolidation of the Family Health Strategy (ESF), having as guiding axis the integrality of actions, promotion and education in participatory and community health[5,6].

In this context, discussions on the construction of a health education policy for SUS were expanded with the aim of overcoming conservative education practices not committed to contemporary principles of health promotion[7] and providing theoretical and methodological instruments for participatory educational approach, especially to ESF professionals.

In line with the principles of the National Health Promotion Policy[8] in 2013, the National Policy for Popular Education in Health (PNEPS)[9] was implemented with a view of achieving improvements in autonomy and self-care of populations of AB[10] territories, with emphasis on the concepts of “empowerment”, “greater participation”, “appreciation of popular knowledge”, “knowledge sharing”, among others[9-11].

Guterman, 2005[4] points out that although the importance of oral health education actions are recognized, in dentistry, attention focused on the individual and with curative activities still predominates, and this situation is reinforced both in academia and in health services. According to Mialhe, Silva (2011)[3], in most dentistry courses, social and educational components are still less valued in student training, thus neglecting an integrated approach to the individual and the determinations established by DCN for dentistry courses aimed at replacing the curative-restorative training model[2].

In 2010, the Dentistry course at the Federal University of Pernambuco (UFPE) implemented a new Pedagogical Project (PP), in order to adapt to the new DCN for health. From then on, changes in the field of theoretical orientation, in pedagogical orientation and in different scenarios of practices in the SUS care network were performed in order to enable students and teachers to have a contextualized and coherent training focused on the needs of local and regional populations[12].

Therefore, the present study aimed to analyze knowledge and practices in health education, recommended by SUS guidelines, of undergraduate dentistry students at UFPE who developed training course guided by this PP, as well as to characterize the sociodemographic profile and to know their perspectives for

professional practice.

2 METHODS

This is a descriptive cross-sectional study with quantitative approach.

The study area was the undergraduate Dentistry course at UFPE, located on the university campus of this university, in the city of Recife, state of Pernambuco. The study population consisted of graduates of this course in 2020.

The curriculum structure of the Dentistry course at UFPE - Profile 6405.1 of the PP started in 2010, and is composed of three training axes (I - health, humanistic and social training, II - health and biological training, III - health and dental sciences), which are articulated over the ten academic semesters/periods in order to promote interdisciplinarity and transdisciplinarity to achieve a generalist, humanized profile of professionals aware of their social commitment and as citizens, capable of responding to social demands[2,13,18]. With minimum length of 05 years, the total course load is 4,545 hours, divided into mandatory curricular components (3,555 hours), elective components (60 hours), complementary activities (90 hours) and supervised curricular internship (840 hours) developed at the SUS network, in a logic of increasing complexity from AB[13].

The sample was census-based, with information obtained on the total number of students enrolled in the last (10th) period of the Dentistry course, which corresponded to a universe of 60 graduates (20 students enrolled in the night shift; 40 students enrolled in the day shift). All students who were attending the 10th period of the course in 2020 and who agreed to respond to the instrument formulated for data collection were included. Not submitting the online form answered in the established period was considered as exclusion criterion.

For data collection, a semi-structured questionnaire was prepared in the online format with pre-coded responses, using the Google Forms platform. The elaboration of questions was preceded by a literature review and in line with the PNPS[8] and PNEPS[9] references adopted by SUS. The questionnaire review process was based on suggestions of Freire and Silva (2006)[14] aiming at a critical analysis of the understanding and order of questions and the acceptability of the instrument as a whole by the interviewer. Two specialists in the Public Health field were selected to evaluate the data collection instrument in order to obtain face validation. The questionnaire was organized into blocks of data: sociodemographic profile and professional perspectives; knowledge about PP; knowledge about health education; and adopted educational strategies and practices.

The invitation to participants was carried out by e-mail, telephone or WhatsApp from November 1 to 11, 2020. Data collection was carried out by a researcher student of the Dentistry course, under the supervision of the supervisor, the responsible researcher. Subsequently, the Google Forms form link was individually sent to be answered, only after reading the information presented in a field of the form, reserved for providing guidance on the importance of answering the questionnaire in a reserved place to guarantee the confidentiality of the information provided, as well as the research objectives in agreement with the Free and Informed Consent Form.

The descriptive analysis of data was performed through the absolute and relative frequency distribution for categorical variables, using the SPSS statistical software (Statistical Package for the Social Sciences).

The research project was approved by the Research Ethics Committee of the Health Sciences Center of UFPE, CAAE: 28941419.8.0000.5208, protocol No. 3.907.460.

3 RESULTS

The response rate was 81.6%, with responses from 49 students, most of them enrolled in the day shift (n=33). In table 1, data on the professional sociodemographic profile showed predominance of females and the age group of 22-25 years. Regarding the reason for choosing the profession, the lowest percentages were related to the work being of self-employed type, financial reward and family influence. As for professional practice, only a minority showed the intention to work as a general clinician (4.1%).

Table 1. Sociodemographic and professional characterization of graduates (n=49)

Variable/category	**n**	**%**
Sex		
Female	38	77.6
Male	11	22.4
Age group (years)		
22-25 years	28	57.1
26-29 years	16	32.7
30-34 years	5	10.2
Reason for choosing the profession (1)		
Family influence	6	12.2
Attractive work field	17	34.7
Financial reward	6	12.2
Self-employed	5	10.2
Respond to community oral health needs	13	26.5
Other	28	57.1
Intention of professional practice		
As a general clinician	2	4.1
As a specialist	26	53.1
Academic career	10	20.4
In the public health sector	7	14.3
In the private sector	1	2.0

(1) Considering that the same respondent could cite more than one alternative, the sum of frequencies is higher than the total number of participants.

Less than half claimed to know the training objectives of PP and the majority considered that there was, in full, articulation of health education knowledge between humanistic, basic and clinical disciplines. It was reported that there are, in part, health education, welcoming and humanization actions in practical classes of clinical disciplines. It was reported that the health education contents are more developed in disciplines of training in axis 1 (health, humanistic and social training) and, subsequently, in axis 3 (health and dental sciences). Regardless of training axis, most participants highlighted the disciplines in which such subjects are experienced, respectively: internships in primary care (75.5%) and in dental clinics (36.7%), the

discipline of Pediatric Dentistry (34.7 %), among others. Regarding pedagogical strategies, transmissive activities predominated and more than half (57%) of participants also mentioned participatory activities (table 2).

The majority (46.9%) related health education with health promotion and disease prevention, followed by the act of transmitting, informing and guiding. Awareness of the importance of oral health, training for autonomy in health care and generating community leadership in the search for improvements in health and living conditions were the aims of oral health education actions most mentioned by participants (table 3). Regarding the pedagogical strategies of oral health education to AB, those that incorporate self-care, positivist approaches for instruction/prevention of oral diseases and the transdisciplinary of multiprofessional action stood out. Less than half admitted the use of active and problematizing methodologies. However, 49% of respondents reported not knowing the PNEPS.

The incorporation of health education in the exercise of future professional work was considered very important (89.9%), with predominance of preference for educational resources used in lectures to support actions. Only 10% reported they did not feel prepared to carry out educational activities and among the reasons, the response that the curriculum was deficient and that the respondent did not feel prepared prevailed.

4 DISCUSSION

The characterization of participants showed that the majority were female, a situation that follows the trend of feminization in Dentistry observed in other studies[15-18].

In relation to the predominant age group being 22-25 years, it was due to the fact that most respondents are enrolled in the day shift, since older students are enrolled in the night shift. This result is in agreement with a national study that recorded the predominance of ages between 20 and 24 years among Dentistry students at the investigated universities[19]. The reason for choosing the profession were diversified, as observed by Lamers et al. (2011)[20] and due to the fact that the work field is professionally attractive, it has become a preference, after other reasons.

More than half of respondents expressed the desire to act as a specialist, as also observed in another similar study[21]. Few respondents expressed interest in working in the public sector, unlike what was observed in 2016 in another study carried out with undergraduates of the same course[18]. Cayetano (2019)[22] identified the idealization of a specialized professional with income above the national average, as an expectation incompatible with the work in dentistry required by SUS, especially AB[10], which requests generalist training[18,22]. However, in this study, financial reward did not predominate in the reason for choosing the profession or the desire to work in the private sector.

Such results may reflect problems related to trends in the dental work market[19], whose professional practice is in crisis. In this regard, it is argued that the decrease in interest in this type of activity, observed among health undergraduates, could be related to difficulties in entering the private market rather than idealized professional intentions[23]. A recent study[24] on reasons for the interest or lack of interest of dentistry graduates in the public health sector identified perceptions that demonstrated that the insecurities of absorption of newly graduated professionals by the private market, which make them choose the public sector for offering employability[19], as reported by one respondent:

“SUS would be a good initial strategy for the beginning [of the career]".

Table 2. Training in health education obtained from the graduates’ point of view (n=49)

Variable/category	n	%
Training Objectives of PP		
Known	23	46.9
Unknown	26	53.1
Articulation of health education knowledge in the subjects of the 3 training axes		
Yes, fully	27	55.1
Yes, partially	22	44.9
In clinical practices, health education, welcoming and humanization actions are incorporated		
Yes, fully	22	44.9
Yes, partially	26	53.1
No	1	2.0
Approach to the theme “Health Education” by training axis and discipline (1)		
Axis 1: Health, humanistic and social training	43	87.8
Axis 2: Health and biological training	8	16.3
Axis 3: Health and Dental Sciences	32	65.3
Did not know	1	2.0
Did not respond	3	6.1
Disciplines most cited by training axis (1)		
Axis 1:		
Health, Education and Society	26	53.1
Collective Health	31	63.3
Axis 2:		
Physiology	3	6.1
Parasitology	3	6.1
Axis 3		
General Clinic	21	42.9
Pediatric dentistry	18	36.7
Patients with Special Needs	17	34.7
*Carried out health education actions promoted by the disciplines**		
Yes	43	87.8
No	6	12.2
If yes, in which disciplines (1)		
Pediatric dentistry	17	34.7
Patients with Special Needs	15	30.6
Internships in Primary Care	37	75.5
Clinical Internships: secondary and tertiary level	18	36.7
Collective Health	7	14.3
Periodontics	7	14.3
Health, Education and Society	7	14.3
General Clinic	16	32.7
Others	9	18.4
Did not respond	4	8.2
If yes, what pedagogical strategies have you adopted (1)		
Transmissive	45	91.8
Participative	28	57.1
Others	1	2.0

* In the activities carried out at the Clinic-School (in the waiting room, individual guidance, others); In Extension Projects; Internships, Campaigns/others. (1) the same respondent could cite more than one alternative.

Table 3. Knowledge of respondents about health education (n=49)

Variable/category	n	%
What do you understand by health education [(1)]		
Health promotion and disease prevention	28	57.1
Transmitting, informing, guiding	23	46.9
Knowledge exchange		18.4
Awareness	7	14.3
Protagonism generator	6	12.2
Population engagement	6	12.2
Objectives of oral health education actions [(1)]		
Raise awareness about the importance of health/oral health	46	93.9
Qualify people for autonomy in health care/oral health	36	73.5
Community leadership in the search for improvements in health and living conditions	34	69.4
Lectures on diet and oral hygiene techniques	28	57.1
Prevent and control the prevalence of oral diseases *	30	61.2
Pedagogical health education strategies indicated for APS [(1)]		
Active and problematizing methodologies	24	49.0
Based on transdisciplinarity used in multi-professional performance spaces	28	57.1
Positivists focused on education and prevention of oral diseases	32	65.3
Strategies that incorporate self-care in oral health	35	71.4
Did not respond	3	6.1
Knows about the National Policy on Popular Health Education		
Yes	25	51.0
No	24	49.0

(1) Considering that the same respondent could cite more than one alternative. * Supervised brushing in schools and other social groups.

More than half of respondents claimed not knowing the objectives of PP according to the articulation of knowledge among disciplines of its three training axes. Another similar study carried out in Rio de Janeiro observed that almost half of teachers and students interviewed perceived the curriculum as relatively integrated[25]. Araújo (2006)[26] emphasized that it is necessary that the pedagogical health education contents go beyond the field of collective oral health and reach all training areas, “ending the dichotomies between basic and clinical, between clinical and social and between public and academic".

Most also reported that the health education contents are more developed in axis 1 (health, humanistic and social formation), especially in collective health and health, education and society disciplines. They also mentioned some disciplines belonging to axis 3 (health and dental sciences). However, given the results obtained, the indication of transmissive educational strategies that shape health behaviors[27] adopted by the surgical-restorative training and care model prevail. Similar results were found among undergraduate Dentistry students in the inner state of São Paulo[3].

On the other hand, among disciplines that

promote health education actions, internships in primary care received the most responses. It is in these training spaces that students can experience the work process of oral health teams and approach participatory and innovative health education practices recommended by PNEPS[9] and thus have elements to question the conservative health education model.

Table 4. Incorporation of educational strategies and practices in the exercise of professional practice (n=49)

Variable/category	n	%
Incorporation of health education into professional practice		
Very important	44	89.8
Important	5	10.2
Indiferent	-	-
Little important	-	-
Not important	-	-
Do you feel prepared to carry out health/oral health education actions?		
Yes	44	89.8
No	5	10.2
If not, why (1)		
Little experience	1	2.0
Unpreparedness	2	4.1
Deficient curriculum matrix	2	4.1
Answered yes to the previous question	44	89.8
If yes, which educational resources should be used? (2)		
Resources used in lectures (slides, posters)	26	59.1
Supervised brushing	10	22.7
Visual/audiovisual materials (videos)	10	22.7
Mannequins (demonstration)	9	20.5
Theater	8	18.2
Brochure/pamphlet/folders	8	18.2
Conversations	8	18.2
Games	5	11.4

(1) Results obtained based on the 5 respondents who answered no in the previous question.
(2) Results obtained based on the 44 respondents who answered yes to the previous question, considering that the same respondent could cite more than one alternative.

Different studies have recorded positive impacts on the academic and personal lives of Dentistry students caused by experiences provided in different practice scenarios in the SUS primary care network[28] and with a focus on health education activities[17]. Toassi et al. (2012)[29] emphasize that internships in SUS provide an expanded and comprehensive learning experience and promote experiences of situations and challenges presented by objective reality and Fonseca (2012)[30] considers that providing opportunities for experiences in AB means promoting the formation of a more humane professional sensitive to the unequal life and health/oral conditions to which low economic classes are submitted[31].

Data revealed that the understanding of most respondents about health education is linked to health promotion and disease prevention actions and almost half reported the act of transmitting, informing and guiding. In another study, it was demonstrated to be prevalent among Dentistry undergraduates the understanding of prevention as synonymous of health education and the concept of health promotion being poorly understood[3], whose main characteristic is the reinforcement of the capacity of individuals and the community to act in the control,

implementation and maintenance of their well-being, in their multiple dimensions[7, 8]. However, when they were asked about the objectives of health education and the pedagogical strategies indicated to APS, a broader understanding of this subject was observed.

Although the results on pedagogical health education strategies for APS have shown greater preference for actions of instruction and prevention of oral diseases, it was found that there is an understanding of the purpose of participatory educational actions requested from APS professionals, either with the adoption of strategies that use participatory methodologies, incorporate oral health self-care and that are based on transdisciplinary with multidisciplinary action.

In the same way, it was observed that most respondents understand the objectives of educational actions and health practices in a broader way, in accordance with participatory and popular educational conceptions[6,32]. Almost half of respondents reported not knowing the PNEPS[9], which demonstrates training gaps in teaching-service integration activities and online disciplines of the dentistry course, as well as of other courses[19]. A study showed that the investigated dentistry professionals had not yet managed to overcome the barrier of the preventive paradigm[4]. Furthermore, resistance from oral health teams to adopting these participatory educational practices[33] is identified, denoting the persistence of conservative education practices focused on lectures and that do not match the health education model required by ESF[34].

Finally, despite the results on the incorporation of health education practices in professional life indicating an affirmative intention, it was observed that the least mentioned educational resources were those dear to participatory and dialogic educational practices. Corroborating the preference of respondents for transmissive educational practices, a similar study carried out in Salvador, Bahia, with EqSB, showed the prevalence of expository lectures with the display of posters and didactic models[35]. Thus, as it has been recurrently demonstrated that the educational actions carried out in the daily practice of dentists are often transmissive or placed in the background[35-37].

It is emphasized that such actions lose part of the educational intentionality required by PNEPS[9], as they do not value the knowledge of the target participants of these actions. In addition, participatory and dialogic strategies and resources are valued in AB for stimulating interaction between oral health teams and users, promoting autonomy, as well as the joint construction of knowledge through its exchange, with valuation of genuine knowledge of community members[11,32,33,38].

Therefore, it is assumed that conservative representation of health education persists in most respondents, which is in agreement with a similar study that identified predilection of undergraduates for transmissive and instructive educational practices[3]. In addition, another study identified difficulties for AB professionals in expressing which pedagogical method they adopt in education and health activities "frequently not knowing to classify and distinguish between resource and pedagogical strategy"[38].

The low external validity of the study as it was carried out with a sample of only one course is considered as a study limitation. On the other hand, methodological care was adopted in the construction and application of the data collection instrument so that the results actually express the opinion given by participants, minimizing information bias.

5 CONCLUSION

Conservative conception of health education persists among Dentistry undergraduates, which is strongly linked to

positivist strategies of transmissive nature and aimed at behavioral changes. Regarding professional perspectives, although PP is aimed at building a generalist professional profile, the option to be a specialist predominated and few showed interest in working in the public sector.

However, it was observed that there was a broader understanding of concepts of participatory and popular health education, when opinions were about the pedagogical strategies indicated to AB. In addition, the objectives of health education aimed at raising people's awareness of the importance of oral health and community protagonism were recognized. This may indicate that there was some influence of teaching-service integration activities in SUS promoted by PP on these results. Planning and monitoring of training strategies are recommended to provoke reflections, experiences and induce health education practices from references of health promotion and education policies to be operationalized by future professionals throughout the Unified Health System.

RESUMO

Conhecimentos e práticas de graduandos de Odontologia sobre educação em saúde requeridos ao Sistema Único de Saúde

Objetivou-se analisar conhecimentos e práticas de formandos em Odontologia sobre educação em saúde requeridas ao Sistema Único de Saúde além de caracterizar o perfil sociodemográfico desses graduandos e identificar suas perspectivas de exercício profissional. Foi realizado estudo descritivo com amostra de 60 alunos da Universidade Federal de Pernambuco, do último período, em 2020. Utilizou-se questionário semiestruturado e de formato *online* na plataforma GoogleForms. Participaram 49 alunos (81,6%). A maioria deseja atuar como especialista (53,1%). Menos da metade (46,9%) afirmou conhecer os objetivos formativos do curso, mas 87,8% consideraram que os conteúdos de educação em saúde são mais desenvolvidos em disciplinas do eixo formativo 1 - saúde, formação humanística e social e no 3 - saúde e ciências odontológicas (65,3%). Predominaram o entendimento de educação em saúde relacionado à promoção e prevenção de doenças (57,1%) e como ato de transmitir/informar/orientar (46,9%), estratégias pedagógicas para ações/práticas educativas das disciplinas transmissivas (91,8%) e a preferência de utilização de recursos educativos para palestras (59,1%). Sobre os objetivos da educação em saúde, conscientizar as pessoas sobre a importância da saúde/bucal (93,9%) e capacitar para autonomia (73,5%) foram respostas prevalentes. A maioria, considerou como estratégias educativas voltadas à atenção básica à saúde as de autocuidado (71,4%,), instrução/prevenção de doenças bucais (65,3%) e baseadas na transdisciplinaridade (57,1%). Incorporar a educação em saúde no trabalho profissional foi considerada muito importante (89,8%). Conclui-se persistir entendimento de educação em saúde fortemente ligado ao conceito positivista de caráter transmissivo, mas compreensão ampliada de caráter participativo e popular formam observadas.

Descritores: Educação em Saúde. Saúde Bucal. Educação em Odontologia. Sistema Único de Saúde. Atenção Primária à Saúde.

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