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Health education in the Family health strategy: nurses' perception

Educação em saúde na estratégia saúde da família: percepção de enfermeiros e enfermeiras

Educación en salud en la estrategia de Salud de la Familia: percepción de enfermeros y enfermeras

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ABSTRACT

Objective: to analyze the practice of health education, developed in the Family Health Strategy of the urban area, from the perspective of nurses. **Method:** qualitative approach, developed in 2019, together with nurses from Family Health teams in a city at the interior of Minas Gerais. The data were collected through semi-structured interviews. The data were analyzed followed by content analysis, thematic modality. **Results:** Four categories emerged: Meanings of health education fos FHS nurses; Elements of the work process in health education; Users facing health education and their interaction with professionals; Possobilities for carrying out health education. **Conclusion:** health education actions should be perceived as actions carried out with the user, in a shared and daily way, guaranteed and valued by management, since they are part of Public Policies, and at any time in the care process by any professional.

Descriptors: Nursing; Public Health; Health Education; Health Ppromotion.

RESUMO

Objetivo: analisar a prática de educação em saúde, desenvolvida na Estratégia Saúde da Família da zona urbana, na perspectiva dos enfermeiros e enfermeiras. **Método:** abordagem qualitativa, desenvolvida em 2019, junto aos enfermeiros e enfermeiras das equipes de saúde da família de um município do interior de Minas Gerais. A coleta de dados ocorreu por meio de entrevistas semiestruturadas. Os dados foram analisados seguiu-se a análise de conteúdo, modalidade temática. **Resultados:** emergiram quatro categorias: Significados da educação em saúde para enfermeiros e enfermeiras da ESF; Elementos do processo de trabalho na educação em saúde; Os usuários frente à educação em saúde e sua interação com os profissionais; Possibilidades para a realização da educação em saúde. **Conclusão:** as ações de educação em saúde devem ser percebidas como ações realizadas junto ao usuário, de forma compartilhada e cotidiana, garantidas e valorizadas pela gestão, uma vez que fazem parte das Políticas Públicas, e em qualquer momento do processo assistencial por qualquer profissional.

Descritores: Enfermagem; Saúde Pública; Educação em Saúde; Promoção da Saúde.

RESUMEN

Objetivo: analizar la práctica de la educación en salud, desarrollada en la Estrategia Salud de la Familia del área urbana, desde la perspectiva de enfermeros. **Método:** abordaje cualitativo, desarrollado em 2019, junto a enfermeros de equipos de salud familiar de una ciudad del interior de Minas Gerais. La recolección de datos se realizó mediante de entrevistas semiestructuradas. Los datos fueron analizados seguido de análisis de contenido, modalidad temática. **Resultados:** surgieron cuatro categorías: significados de la educación en salud para enfermeros de la ESF; Elementos del proceso de trabajo en educación en salud; los usuarios ante la educación en salud y su interacción con los profesionales; posibilidades de realizar educación en salud**. Conclusión:** las acciones de educación en salud deben ser vistas como acciones realizadas junto al usuario, de manera compartida y diaria, garantizadas y valoradas por la gestión, ya que son parte de las Políticas Públicas, y, en cualquier momento del proceso de atención, por parte de cualquier profesional.

Descriptores: Enfermería; Salud Pública; Educación em Salud; Promoción de la Salud.

INTRODUCTION

Education in health consists of a set of activities that provide knowledge, promote reconstruction of the meanings of life habits, strengthen organization of the health network, and contribute to social control with a view to empowerment and autonomy of the individual/user[1-3].

From Freire's perspective, for education in health to be effective, it is essential for professionals to have a global and expanded view of the individual and the context. It is fundamental to resort to dialog, with exchange of knowledge/understandings, without the educator imposing any truths, building shared and humanized knowledge[1].

The Banking Theory represents the education methodology in which a knowledge holder, in this research the nurse, will deposit their health knowledge in the users, as if they were an empty container to be filled. This does not

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promote awareness and autonomy, but reinforces the prescriptive perspective. It reveals an authoritarian and vertical relationship, with information transfer to memorize the topics covered[4,5].

On the other hand, there is the Dialogic Theory, anchored in an exchange of experiences and knowledge between those involved, professionals and users, aiming at the construction of significant knowledge, for awareness raising to transform behaviors and attitudes. It presupposes horizontal interpersonal relationships and collective construction of knowledge[6].

The Family Health Strategy (FHS) needs to transform the assistance provided through a multidisciplinary team, offering longitudinal and comprehensive care to the users, mainly using education in health[7].

In this context, educational practices with the individual are often attributed to nurses. This can be explained considering that the educational dimension is one of the pillars of their training, preparing them to be facilitators of the teaching-learning process. For this, they need to appropriate scientific and popular knowledge to bring theory and the reality experienced closer together[8]. We emphasize the importance of the participation of other professional categories in the construction of knowledge among the population, practices contextualized to the realities experienced and a more comprehensive view of the users, with the involvement of physicians, psychologists and occupational therapists in health education[9-11].

To analyze the education in health practice from the perspective of nurses working in the FHS/urban area, an approach to the Banking and Dialogic Education theory by Paulo Freire was carried out. The proposal is convergent with health education in the FHS context, considering the need for users to be recognized and considered as protagonists of their choices, understanding that education in health demands the construction of dialogic and shared relationships.

Investigating the education in health practice from the perspective of FHS nurses can help managers and professionals to strengthen positive aspects and rethink everyday weaknesses, enabling greater consistency between actions taken and social demand. In addition to that, a gap in the international scientific production on the theme was verified, in the specific context. This study aimed at analyzing the education in health practice, developed in the Family Health Strategy in the urban area, from the nurses' perspective.

METHOD

An exploratory study with a qualitative approach was carried out, following the Consolidated criteria for reporting qualitative research (COREQ). The research was carried out in 2019, with 47 teams from the FHS/urban area, in a municipality in the inland of Minas Gerais, which belong to a number of Health Districts and each one is responsible for an ascribed area.

Of the total of 47 FHS nurses, at the time of data collection, 23 participated in the study, intentionally selected, not using the saturation criterion and obeying the following inclusion criteria: being a male or female nurse and working in the FHS for at least six months.

A total of 24 professionals were excluded, of which 12 were on vacation, eight were undergoing training outside the unit, and four were not found after three attempts to schedule the interview. Data collection took place through semi-structured interviews guided by a script submitted to face and content validation by three PhDs in the subject matter and/or research methodology. It included sociodemographic data and questions regarding the male and female nurses' understanding of education in health, its conduction in the FHS, and factors that facilitated and hindered their practice. A pilot test was carried out to test the aforementioned script under real conditions, with nurses from PHC, but not from the FHS.

The interviews were conducted by the researcher herself, who received prior training from the research supervisor. Telephone contacts were made to schedule and explain the reason for the study. They were audio recorded in digital media and applied face-to-face, at the FHS, in a room that ensured privacy. During the interviews, only the researcher and the interviewee were present in the private room. They were fully transcribed by the researcher and lasted a mean of five minutes. The participants were named E1, E2, E3 and so on until E23, where the letter "E" meant interviewee ("*Entrevista*" in Portuguese) and the number represented the sequence according to the order of the interviews.

The data collected referring to the interviewees' characterization were submitted to descriptive analysis. For the qualitative data analysis, the methodological guidance of content analysis was followed, in its thematic modality, which seeks the cores of meaning to respond to the research objectives[12].

The research complied with Resolution No. 466/12 of the National Health Council, and was approved by the Research Ethics Committee of a Federal University. It integrates a larger project entitled: "Perception of education

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in health at Primary Health Care". The participants signed an Informed Consent Form, ensuring confidentiality and anonymity.

RESULTS AND DISCUSSION

Among the 23 participants, 22 (95.65%) were female and one (4.35%) was male, aged between 29 and 57 years old, with a mean age of 35.47. Regarding training, all had some type of complementary training, 23 had a specialization, six (26.08%) had a master's degree and one (4.34%) was a PhD.

Four thematic categories emerged from the analysis of the speeches, namely: Meanings of education in health for FHS nurses; Elements of the work process in health education; Users facing education in health and their interaction with professionals; Possibilities for carrying out education in health.

Meanings of education in health for FHS nurses

The perception of education in health as activities for professional qualification/training was evidenced, revealing it as synonymous to permanent education:

> *(...) with the team. I really appreciate this team issue, I've always trained my team, I want my team to grow (...) I believe that's it [referring to education in health]. (E3)*

This finding diverges from the literature that defines education in health as the relationship between male/female nurses and users in order to build knowledge and share it among those involved[1]. On the other hand, permanent education represents a professional qualification strategy to lead to reflection on the work process, self-management, institutional change and reconstruction of the in-service practices, improving the health team's work process[13], differing from education in health[14,15].

From another perspective, there was the perception of education in health as actions performed with the users/population, either in groups or individually, guiding from biological issues, health promotion and disease prevention, to organization and flow of the service. Such actions are carried out daily and at all times of the professional-user interaction:

> *(...) every time the user is in the unit is the time for you to actively search and be doing education in health. (E11)*

This converges with the literature by highlighting that education in health is the construction of health knowledge among the population, not occurring due to the imposition of scientific knowledge, so that users can appropriate the knowledge[16].

The meaning of education in health at the FHS emerged, based on the transmission/transfer of health information from the professional to the user:

> *(...) education in health for me is transmitting a message, some guidance to the patient (...) sharing knowledge with the patients (...) we're transmitters of information. (E19)*

This statement, based on health education in the logic of transmitting knowledge and valuing scientific knowledge at the expense of people, is in line with the theory of Banking Education, which brings to light the idea of someone as the holder of information, transmitted and deposited in the other[16,17], focusing on diseases and indicating what is right and wrong[7].

This is in line with the biomedical care model, influencing the education in health practice as the transmission of knowledge and the prescription of treatments and attitudes by the professional. Banking Education is based on mechanistic teaching models, not enabling reflective and critical processes[18].

On the other hand, education in health emerged as an exchange of knowledge, configuring a dialogic and participatory aspect, aiming to promote the individuals' autonomy:

> *Education in health is a way of making people autonomous, that they know and can make their own decisions in relation to health (...) education in health is a way of making the user responsible for their health, not a passive being (...). (E6)*

The statement above converges with the literature by evidencing that education in health activities make it possible to promote user autonomy and self-care through the shared construction of knowledge, encouraging their protagonism[16]. It is fundamental that education is sustained by dialogicity, implying (re)construction of knowledge as its unveiling, the process of singular awareness raising and the condition of historical and unfinished beings[5].

In this dimension, it is suggested that education in health be carried out horizontally between professional and user[19], as proximity and bonding enable horizontalized, dialogic relationships and greater participation of those involved[20]. A close

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connection with Paulo Freire's framework is evidenced, by highlighting that popular education transforms subjects into active and autonomous participants in their own change, as well as in the world's transformation[5].

Elements of the work process in health education

Perceptions emerged ranging from the availability and use of material and non-material resources in the work process and the number and involvement of professionals, to service management. This thematic category brings together facilitators and obstacles to achieving education in health at the FHS.

For the interviewee, having an appropriate location and sufficient and available material resources facilitate the health education practice in the FHS.

> *What harms the most (...) is the lack of chairs, lack of a suitable environment and type of overhead projector, something nice for you to do, a TV set to show a movie. We don't have these materials, it limits us very much, we usually research and talk about the subject matter (...). (E1)*

It was found that adequate material instruments and infrastructure are facilitators, converging with the literature which highlights that hard technologies enable user understanding and participation in health education[21].

For the participants, inadequacy of material resources makes it difficult to carry out the activities. They highlighted that the professional's guidance/information is not always consistent with what is available in the health service/system, such as the conduction of preventive exams:

> *(...) sometimes the delay of the health system makes it very difficult (...) we do campaigns for women's health, then you hit that button that she has to have a mammogram, Pap smears every year, but the Pap smear takes a long time to get the results (...) this sluggishness of the health system sometimes gets in the way. (E10)*
>
> *(...) decorating the unit with the themes, making a brochure with the theme, that's all we do, all we're going to do comes from our own resource, so this makes it a little difficult, if the City Hall could collaborate more in this part, it would help a lot. (E16)*

The FHS routine is impacted by insufficient material resources, and the professionals often bear the expenses to promote health education actions. These findings converge with the literature by asserting that the FHS lacks material resources necessary for health education activities. The use of different resources facilitates dialog with the user[22].

In the SUS, there is a long wait, months or even years to be able to refer a user, this delays diagnoses, compromises the patient's prognosis[23] and, many times, discredits the system.

For the participants, the work, the team's interest and the interaction between the work process agents, considering knowledge complementarity, facilitate education in health:

> *(...) a team that really works as such (...) counting on the participation of other professionals is also enriching (...) a physical educator here would be interesting because he would help us with education in health. Physiotherapist, nutrition (...). (E6)*
>
> *The first thing is the partnership with the community health agents themselves, because if they don't inform us nurses, how can we get to that community? (...) sometimes, we make mistakes! Because each population has a different receptivity (...) the first thing is this partnership with them, them embracing the cause with us. (E11)*

The findings converge with the literature when advocating that, when there is collaboration among the team members, from the discussion and construction of actions to the execution of interventions, comprehensive care is enhanced[24]. It is fundamental that health care/education is carried out by the multidisciplinary team and not restricted to a class, discussing the necessary actions[25].

Safe health care that generates satisfaction in professionals and users alike requires effective communication and collaboration at work from the team[26,27].

On the other hand, the participants revealed that their work overload and low motivation with education in health hinders this practice. They highlighted that they need time to prepare the activity, revealing that this is understood as planned actions and not as something that permeates the entire work in health process:

> *(...) lack of commitment of the professionals themselves, they also sometimes feel unmotivated to do this type of action. (E9)*
>
> *(...) what makes it difficult is that we don't have time to prepare it (...) I see myself having to prepare the health education things (...) at home! (...) I think that if we had some time set aside in those 40 hours. (E14)*

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The participants revealed motivation to carry out education in health. However, work over load precludes it. FHS nurses have intense work demands and must respond to the needs of the population, with scarce resources. They need to coordinate the team and execute public health policies, which can compromise such activities[28,29].

Lack of management involvement and support emerged as an obstacle to education in health at the FHS:

> *(...) when we have an immediate supervisor who understands the need for this, its importance makes it easier! Because when you have a boss who thinks that you're wasting time... then it gets very difficult. (E3)*

The absence of management involvement and support is noteworthy as a hindrance to education in health. The literature finds lack of interest from health managers in health education activities, considering them useless, prioritizing consultations and drug prescription as the most relevant actions[22].

Users facing education in health and their interaction with professionals

The interviewees revealed that the way in which users deal with education in health and their interaction with the team can hinder or facilitate their practice in the FHS.

The reports expressed that the team-community bond and the users' receptivity facilitate the development of education in health:

> *(...) a very important thing about the Family Health Strategy is the bond, that we end up getting to know this population, it's always there and we really create a bond. People look for you (...). This makes it much easier, the fact that we can enter the person's house too, watch, see their reality, listen to how they live, all of this makes the work easier. (E4)*

> *(...) the patients' receptivity to see that [referring to education in health] as good guidance, as something that really has to add to their life. (E17)*

These findings converge with the literature which advocates that the bond represents an important professional-user link, provides security, enables knowledge exchange, and promotes autonomy in self-care, anchored in qualified listening, welcoming and mutual respect[30,31]. When based on the construction of the bond, the work of FHS male and female nurses brings the demands of the population closer to the care provided[28].

True humanization is not achieved through “deposits”, as proposed by Banking Education, but through action and reflection about the world. The subject's liberating and problematizing education presupposes a creative, critical and conscious being[18].

On the other hand, it was found that ineffective communication and inadequate interaction between professionals and users hinder the health education practice:

> *(...) what makes it most difficult (...) It's about you being able to communicate with people according to (...) their level (...) speaking the same language (...) another factor that makes it difficult (...) if you already have a frayed interpersonal relationship [referring to the relationship between professional and user] (...) it also makes it difficult. (E2)*

Adequate and effective education in health considers popular education for a good interaction, valuing the knowledge of the population and not only scientific knowledge. It is fundamental that the professional is close to the user's reality so that communication enables shared knowledge[8]. Reflecting on the transformation from this pedagogical perspective requires initially valuing the popular knowledge-object of popular education, eliminating dichotomous, unidirectional and hierarchical relationships of oppression. Freire's liberating pedagogy foresees an authentic practice in conducting a theory linked to the social reality[18].

Low community involvement, devaluation and weak adherence to groups hinder health education in the FHS. For the interviewee, the population still wants medicalization, revealing the perpetuation of the biomedical model:

> *(...) a little understanding of the population because sometimes you say 'ah come join a group'. ‘Ah! But it's just education in health’. Sometimes they wait for a remedy, they are still having a hard time! Many have already understood, but for the others it's a transition (...) (E6)*

The finding converges with the literature by evidencing the medicalocentric model as hegemonic, and the existence of authoritarian and prescriptive education with the exclusive objective of behavioral change[32]. The aforementioned model and Banking Education, anchored in vertical/authoritarian relationships and holders of knowledge4, support the testimony. Therefore, groups that aim at promoting health through educational activities that generate autonomy in self-care become little frequented[33].

Possibilities for carrying out education in health

It emerged from the findings that education in health should be institutionalized as a mandatory action and that the management should demand that other professionals carry it out, not being solely a Nursing responsibility:

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> *The demand by the management for all professionals and not just the nurses. Most of the times (...) Nursing ends up talking about topics that (...) we're not even qualified to talk about, because we don't have the right professionals. It is to encourage the employees themselves and make it more of a routine (...) so the population starts to get used to this type of action. (E9)*

Education in health at the FHS must be developed by the multidisciplinary team.

However, it is generally carried out by the nurses[19]. Essential involvement of the entire team/FHS, aiming to articulate knowledge, build an interdisciplinary practice and minimize the burden of only one professional[34].

As proposals to carry out education in health, it was indicated to enable the professionals' agenda to reconcile care and health education groups:

> *(...) we did it here with a group of pregnant women (...) on the consultation day (...) we're doing the group before the consultation (...) the doctors (...) they only start after the group has been held (...) it was a strategy that we used and that is working (...) we managed to bring more pregnant women to the group (...) (E4)*

The statement highlighted the need to organize work in a horizontal and multi-professional way to meet the users' demands. The waiting room is an effective strategy for sharing experiences in health education groups on various themes[35].

Study limitations

Despite the limitation regarding the fact that the research was carried out only with nurses, it was expected to reveal the meaning and practice of education in health from the perspective of the professionals who perform it the most. This can signal changes to be made with a view to comprehensive care.

CONCLUSION

In the study context, the perception of education in health is changing. Perspectives emerged that emphasize education in health as something punctual, with planned days and times. On the other hand, there was a manifestation of the transversal role of health education in the nurses' routine.

The community's attitude towards health education actions is in a process of changes in socio-historical-cultural attitudes, with repercussions in the theoretical-practical actions carried out by professionals. Such findings reveal progress towards the foundation of health education in the FHS, a fact that needs to be enhanced by managers and governmental agencies, highlighted as a contribution of the study.

Some professionals conceive education in health as disconnected from their usual activities. Other interviewees confuse it with permanent education. An important finding stands out, which makes it difficult to carry out these activities, as well as the absence of management support and lack of interest from the population.

As study contributions, most of the scientific production limits health education actions from a biomedical/banking perspective, through lectures or strategies such as conversation circles. However, the literature does not reveal the importance of local management being engaged and facilitating, in addition to the still distorted perception of its meaning, such as the equivalence to permanent education.

Health education actions need to be understood as those carried out with the user, in a shared and daily manner, at any point in the care process by different professionals, guaranteed and valued by the management, as they are part of the public policies.

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