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ORIGINAL ARTICLE

Perception of the Primary Care multiprofessional team on health education

Percepção da equipe multiprofissional da Atenção Primária sobre educação em saúde

Percepción del equipo multiprofesional en la Atención Primaria sobre educación para la salud

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ABSTRACT

Objective: To understand the perception of the Primary Health Care multiprofessional team on the practices of health education and on the role of nurses in the performance of educational activities. **Method:** Exploratory and descriptive study with a qualitative approach. Data were collected through a semi-structured interview with the participation of 12 professionals from the Family Health Strategy. To analyze the data, we used the technique of content analysis, with thematic approach, proposed by Bardin. **Results:** Three categories emerged: *Perception of the multiprofessional team on health education*; *Educational practices in Primary Health Care: everyone's task?*; and *The role of nurses in health education*. **Final considerations**: It was verified that the multiprofessional team perceives health education as being the responsibility of all the professionals. Some professionals consider the nurse as an important educator, others as executor of management and care actions and, to a lesser extent, of educational actions.
Descriptors: Primary Health Care; Unified Health System; Public Health; Health Education; Nursing.

RESUMO

Objetivo: Compreender a percepção da equipe multiprofissional da Atenção Primária à Saúde sobre as práticas de educação em saúde e sobre o papel do enfermeiro no desempenho das atividades educativas. **Método:** Estudo exploratório e descritivo, com abordagem qualitativa. A coleta dos dados ocorreu por meio de entrevista semiestruturada com participação de 12 profissionais da Estratégia Saúde da Família. Para análise dos dados, utilizou-se a técnica de análise de conteúdo, com abordagem temática, proposta por Bardin. **Resultados:** Emergiram três categorias: *Percepção da equipe multiprofissional sobre educação em saúde*; *Práticas educativas na Atenção Primária à Saúde: tarefa de todos?*; e *O papel do enfermeiro na educação em saúde*. **Considerações finais**: Verificou-se que a equipe multiprofissional percebe a educação em saúde como sendo responsabilidade de todos os profissionais. Alguns profissionais consideram o enfermeiro como importante educador, outros como executor das ações gerenciais e assistenciais e, em menor proporção, das ações educativas.
Descritores: Atenção Primária à Saúde; Sistema Único de Saúde; Saúde Pública; Educação em Saúde; Enfermagem.

RESUMEN

Objetivo: Comprender la percepción del equipo multiprofesional en la Atención Primaria de Salud sobre las prácticas de educación para la salud y sobre el rol del enfermero en el desempeño de las actividades educativas. **Método:** Estudio exploratorio y descriptivo, con abordaje cualitativo. La recolección de los datos ocurrió por medio de una entrevista semiestructurada con participación de 12 profesionales de la Estrategia Salud de la Familia. Para el análisis de los datos, se utilizó la técnica de análisis de contenido, con abordaje temático, propuesta por Bardin. **Resultados:** Se plantearon tres categorías: La percepción del equipo multiprofesional sobre educación para la salud; Prácticas educativas en la Atención Primaria de Salud: tarea de todos?; El rol del enfermero en la educación para la salud. **Consideraciones finales:** Se verificó que el equipo multiprofesional percibe la educación para la salud como responsabilidad de todos los profesionales. Algunos profesionales consideran al enfermero como importante educador, otros como ejecutor de las acciones gerenciales y asistenciales y, en menor proporción, de las acciones educativas.
Descriptores: Atención Primaria de Salud; Sistema Único de Salud; Salud Pública; Educación para la Salud; Enfermería.

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INTRODUCTION

The Brazilian Unified Health System (SUS - *Sistema Único de Saúde*) structures health care at three levels: primary, secondary and tertiary. These levels are organized in an articulated and orderly manner, aiming at offering comprehensive health care, promoting the promotion, prevention, recovery and rehabilitation of individuals. In this perspective, Primary Health Care (PHC) is recognized as a privileged field for the development of these actions[1-2].

The PHC is one of the entrance doors of the SUS, being configured as a preferred contact of the users and communication center of the Health Care Network (RAS - *Rede de Atenção à Saúde*). It is also added that PHC must be developed with the highest degree of decentralization and capillarity, because it is located as close as possible to the territory where the community is inserted. Aiming at reorganizing this level of care, the Ministry of Health implemented the Family Health Strategy (FHS) as a strategy to expand, qualify and consolidate PHC[3].

The work organization proposed by the FHS points to the need for teamwork, since the joining of the different professional categories favors interdisciplinarity, which interferes positively with the solvency of health problems in the assisted community, in addition to provide comprehensive care to individuals[4].

The professional categories that make up the Family Health Team are distinct, with emphasis on the doctor, nurse, dental surgeon, auxiliary or technical in oral health, nursing technician or auxiliary and Community Health Agents (CHA). To this team are still added the professionals of the Family Health Support and Primary Care Center (NASF – AB - *Núcleo de Apoio a Saúde da Família e Atenção Básica*), who are part of different areas of knowledge and act in support of the reference team[3]. This team should develop health practices aimed at completeness[5], and in this context the promotion of health is evidenced as one of these responsibilities.

Health promotion is a practical and conceptual form of public policy that aims to give autonomy and foster self-care, through the search for quality of life, both the individual and the collective. In the PHC, this promotion is mainly expressed through health education[6]. Health education practices serve as a focus for the reflection of the population, since they provide a comprehensive care and are transformative in character, making users active in health and autonomy[7], allowing them to rethink about the reality in which they live and opt for healthier choices, as well as encouraging changes in individuals' risk behaviors[8]. Health education activities may occur in the office, in individual care, and collectively in groups or in conversation[7].

It is shown, therefore, that when these health education practices are developed by the multiprofessional team, they end up involving a greater diversity of knowledge, contributing to the creativity and the greater adhesion of the users. This fact, together with the decentralized knowledge of the professional, is constituted in structural strategies, to make educational activities in spaces of knowledge sharing[9]. However, in spite of the importance of these educational actions, studies suggest that these interventions are concentrated in some professionals of the team[8].

Among the professionals who make up the multiprofisisonal team, nurses have their practices based on two main components: management and care, but in the second, there is a greater development of health education practices[10], with a predominance of orientation actions and informative information acquired at the time of consultations and collective educational activities[7]. However, the execution of educational activities that are rooted in the second component presents difficulties in the reality of PHC, since management actions and the attendance to the programs demand nurses' time[8]. These professionals consider that there is unequal accountability about the class, and such a problem entails work overload and overlapping of activities, thus generating difficulties, even with regard to the practice of care[11].

It is worth emphasizing that through professional practice it is possible to identify that some professionals of the Family Health Team ignore educational practices performed by the nurse, not recognizing this professional as a health educator, and associating in his image the accompaniments of the programs and the management.

In view of this reality, the Scientific and Technical Literature of Latin America and the Caribbean (LILACS) and Scientific Electronic Library Online (SciELO) databases were searched in September 2016, using the controlled descriptors "Nurse", "Health Education" and "Primary Care", where 58 articles were identified that did not respond to the concerns raised by the authors. Therefore, the study is justified by the gaps evidenced in the literature regarding aspects of health education[12], and especially regarding the perception of the Primary Care multiprofessional team on health education actions, including those performed by the nurse . Thus, it is believed that the study will make it possible to identify the perception that multiprofessional professionals inserted in the FHS have regarding the health education practices developed in this level of care.

Considering the above, the following questions emerged: What is the perception of the multiprofessional team about the role of nurses in health education? What is the perception of this team about health education? In order to respond to the aforementioned concerns, this study had as its object the perceptions of the multiprofessional team on health education and the role of the nurse in this context.

OBJECTIVE

To understand the perception of the PHC multiprofessional team about practices of health education and about the role of nurses in the performance of educational activities.

METHODS

Ethical Aspects

This study complied with national and international standards of research ethics involving human subjects. It followed the recommendations proposed by the National Health Council *(Conselho Nacional de Saúde*), in Resolution 466/2012, which regulates research guidelines and regulations involving human subjects and obtained approval from the Research Ethics Committee of the *Escola de Saúde Pública do Ceará* (ESP/CE). The participation of the professionals was consented, by means of the signing of the Free and Informed Consent Term.

As a way of preserving the anonymity of the interviewees, the first initial of the professional category name of the participant and the letter R to identify in the case of the resident professional, preceded by an Arabic numeral, which corresponded to the order of interviewing, was left. For example, for the first resident physiotherapist, he was called RPH01. This denomination was carried out in the following categories: social worker, nurse, psychologist, nutritionist, physiotherapist and doctor, except in the CHA category, which was used the acronym CHA, succeeded by the number according to the order of the interviews.

Theoretical-methodological framework and type of study

This is an exploratory and descriptive study, with a qualitative approach, carried out from February 2016 to March 2017.

Methodological procedures

Study setting

The study was carried out in the city of Aracati, on the eastern coast of Ceará State. Currently, the municipality has 20 FHS, corresponding to 83% coverage[13]. For the study, two FHS and the corresponding NASF-AB were selected for convenience, because they were located in the urban perimeter of the city.

In order to select these professionals, the following inclusion criteria were adopted: be a professional or multiprofessional resident in Family and Community Health of the ESP/CE of one of the two FHS, and have at least one year of PHC experience[14].

The sample was composed of six residents: two physiotherapists, one social worker, one psychologist, two nutritionists and six professionals working in the service: one doctor, three nurses and two Community Health Agents. Twelve professionals participated in the study which make up the reference team and the support team of different categories, and adopted the data saturation referential for the finalization of the sample when appropriate[15], considering the criteria related to the depth of the thematic, contextualization and understanding of the objectives proposed in the study.

The multiprofessional resident team was included in the study because the NASF-AB staff consists only of residents and fit them into the adopted criteria, as well as because it is understood that residents are practicing and responsible professionals in the territory. In addition, they provide care in the community, showing their perception about what is around them and has autonomy to carry out the activities of the territory.

Collection and organization of data

The data collection took place from February 2016 to March 2017, through a semi-structured interview and application of an instrument prepared by the authors, containing data related to sociodemographic characterization.

The invitation to participate in the study occurred from the evaluation meetings that took place in the selected health units. These meetings were held on a monthly basis, and were a rich opportunity for dialogue with the professional staff. The interviews were scheduled according to the availability of the interviewee, by prior appointment, so as not to interfere with their work dynamics. For participants who were not present on the day of the meetings, the contact occurred in person or by telephone.

The interview was conducted individually with the participants in the BHU reserved room and lasted approximately 20 to 30 minutes. It was composed of eight guiding questions, covering the following themes: the perception of the multiprofessional team on health education, the characteristics of educational activities carried out at the BHU and the professionals who performed them, the characteristics of the nurses' work at the FHS, educator in health, and seek reflection on the role of professionals inserted in the BHU in educational practices. The interview was recorded on audio equipment for later transcriptions.

Data analysis

For the systematization and analysis of the data, we used the content analysis technique, with a thematic approach, proposed by Bardin. After the interviews, the data analysis was divided into three stages: a) Pre-analysis; b) Analytical description; c) Treatment of results. The first step was the transcription of the interviews, the reading and the preliminary grouping of these data. In the second stage, the correlation of the themes and their classification into empirical categories occurred. Finally, during the third stage, the discussions and connections between the collected data and the scientific literature[16] were preceded. The process of analyzing the information gave rise to three thematic categories: *Perception of the multiprofessional team on health education*; *Educational practices in Primary Health Care: everyone's task?*; and *The role of nurses in health education*.

RESULTS

Regarding the characterization of the twelve participants of the study, ten participants had a higher level and only two participants were male. As to the color, seven were self-declared brown, two black and three white. Regarding the age group, subjects were between 24 and 43 years of age, with a mean age of 29 years. The average service time at the PHC was four years. The results obtained were analyzed and the thematic categories identified are presented below.

Category I: Perception of the multiprofessional team on health education

Considering the importance of identifying the PHC professionals 'knowledge about health education, this category analyzed the participants' considerations on this subject. According to reports, health education can be identified as a strategy whose purpose is to prevent and promote the health of the population assisted. In addition, it assists in improving the quality of life of these subjects, as evidenced in the following statements:

> *Health education is working with the community to prevent diseases, and to encourage these people through activities to have a better quality of life.* (N01)

> *It is to train the users, the people, is to bring information to the people about diseases.* (CHA02)

On the other hand, some professionals pointed out that health education is a face of care, having an empowering characteristic. In their speeches, it was also evident the need for these activities to be carried out in an environment of knowledge sharing, focused on the experiences and interests of the community and also betting on active methodologies.

> *Health education is a process of information exchange between different individuals, in which there are exchanges of experiences for the purpose of health promotion, disease prevention covering the various biopsychosocial issues of subjects.* (RN01)

> *Education is a tool of great importance for the empowerment of patients, generating co-responsibility on their health, as patients, these will be activated to take responsibility for their health* [...] *Health education should be something flexible where the prior knowledge of patients should be taken into account.* (N02)

Affirmations have also been identified that emphasize the contributions of educational actions in the professional's relationship with the user, helping to create links between the actors in the process.

> *Education fosters the link between professional and client, thus providing a relationship of trust between both parties, qualifying patient follow-up/treatment/recovery.* (N02)

Category II: Educational practices in Primary Health Care: everyone's task?

This category deals with professionals' perspectives on the implementation and responsibility of educational practices in the PHC. The understanding of a significant role in health education actions by the whole multiprofessional team was evidenced. Participants mentioned that the activities directed to health education are tasks of all involved in the PHC and regardless of the professional category or level of training.

The professionals emphasize that each individual has contributions to these moments of education, because each subject brings their experiences and knowledge to the practices, giving more quality to educational sessions, according to the following report:

> *All professionals must carry out educational activities, since each one can contribute collectively and individually according to their professional skills and abilities, since the health of the family must involve all the professionals of the team for the best care for the population.* (S01)

In the reality of the FHS investigated, health education activities are carried out with greater emphasis by the professionals of the multiprofessional residency that work in the municipality, with emphasis on NASF-AB professionals and resident nurses who are linked to the reference team.

> *In the experience of the territory, the resident nurses and NASF-AB professionals carry out health education unlike the nursing professionals of the municipality.* (RN02)

> *Right here in the unit ends up being more NASF-AB people due to the demand.* (D01)

> *Resident nurses, nutritionist, social worker, psychologist, physiotherapist.* (N01)

Some speakers point out that, although nurses and doctors have important knowledge to contribute in collective moments, these professionals do not provide time for the execution of these activities, being in turn, responsible for the articulation of these moments. This fact may be associated to the demand for work and the overvaluation of individual care.

> *In fact health education should be everyone's responsibility, but this activity ends up being mainly charged by the NASF-AB, where professionals of the Strategy sometimes end up being restricted for the most part to outpatient care.* (RP01)

> *Health education is the responsibility of nurses, because it is a profession that works with the population, with the community, and has more ability, they are professionals that have a logistical vision about the problem of that person and the pathologies.* (N03)

> *Nowadays it is NASF-AB staff that performs* [health education], *but it could be the nurses. In this respect it leaves much to be desired.* (N01)

> *NASF-AB residents and resident nurses are the ones who carry out educational activities, we do more in the office.* (N02)

Category III: The role of nurses in health education

In this category, the considerations on the role of the nurse in the PHC educational practices are presented. The unique role of the nurse in health education was evident, since he is referred to as facilitator of these actions, instigator of the team and articulator of that moment. Due to its proximity to the users of the territory and its experience, this professional has the facility to list the most pertinent themes to be addressed in the moments of health education, according to the following statements:

> *Nurses are fundamental in health education, they articulate services and are key players in performing some activities. The nurses' view on the health situation of the territory would facilitate activities, places and subjects to be addressed.* (RN01)

> *The role of nurses in health education encompasses the main themes pertinent to the territory to be addressed in the activities; seek from the Team Community mobilization strategies; facilitate some health education activities; instigate the team to carry out health education* (RS01)

It is also evidenced the role of counselor of this professional, as well as his strategic role in these activities, being seen as responsible for the care and empowerment of users regarding health and quality of life, conferring autonomy to the subjects.

> *Nurses have the role of forming, developing and empowering the community, as well as allowing the community to be protagonists of their lives, empowering them with knowledge that facilitates their daily practices for a healthy life.* (RPH01)

> *Nurses play a very important role in health education, because it develops the work of following up families and the community, in which it knows the demands of this community.* (CHA 01)

However, it was common in the speeches to highlight the nurse as an organizer of the actions of education in Collective Health, leaving educational sessions delegated to NASF-AB professionals. According to the interviewees, this is due to the high number of other functions for which this professional is responsible within the FHS, leaving these activities in the background. These professionals call themselves executors of all the activities carried out in the health establishment, which can influence the execution of health education.

> *Nurses are fundamental, but they are busy professionals within the activities performed at the FHS. Where they have to manage an entire BHU and still do their professional role. What ends up demanding a lot.* (RP01)

> *In the health center the nurse is one thousand and one utilities.* (CHA 01)

> *I have so many responsibilities, I do everything a little* [...] *I do so much in the unit that is even hard to remember. (*N01)

> *We should do more health education, but the time is so long that it is a little missing that part, it is more in charge of the NASF-AB staff.* (N01)

> *Most of the time the nurse is not responsible for a health education activity, since it is more focused on care. However, it has a very important role in identifying the weaknesses in its territory and articulating with the NASF-AB the actions.* (RN02)

It is evidenced that health education activities carried out by these professionals are made at specific times and in a timid manner, carried out mainly in campaigns, as identified in the statements that follow:

> *I carry out health education in follow-ups, in childcare, in antenatal care, and during prevention.* (N03)

> *I only perform health education in the consultation, most health education actions are done in individual care, we carry out health education in the consultation of pregnant women.* (N01)

> *The nurse of the health center ends up performing more health education activities in the campaigns like trachoma, HPV, when it has the pink October, but ends up being more in the same campaigns.* (D01)

DISCUSSION

The results of the present study emphasize that health education was understood as an information transmission tool. Even though this model of education proves ineffective to meet users' needs, many health professionals are based on the reductionist and positivist view of health education, whose practices seek to adopt behaviors considered adequate[17]. It is worth stressing that the model considered effective is based on dialogical practices[18].

However, the discourse of the participants refers us to a field of hegemonic practices, described as authoritarian, prescriptive, limited to behavioral changes, which seeks the biological aspects of the health-disease process, neglecting the others. In this model, the human condition is reduced to pathology, conditioning the individual to a system based on rewards, whose practices may be mixed with dialogic practices[18].

On the other hand, health education was also referred to as a means of empowerment. Pedagogical practices that use active methodologies, based on the participant's experiences, encouraging them to problematize and participate, leading to a more efficient learning process, is characterized by being a dialogic practice[18]. These practices aim at the autonomy of the subjects, being the PHC an environment with great potential for the development of intersectoral actions, popular participation, and individual and/or collective empowerment[19].

The discourses that aim to share knowledge among professionals and users and have as a characteristic a concept of health education that values collective constructions and respects the knowledge of the other, is based on the ideal of the *Educação Popular em Saúde* (Popular Education in Health)[9]. Popular Education in Health, in this perception, appeared in the 1950s, with Paulo Freire. Their assumptions, added to the health actions, provided a new articulation between education and health, that began to consider the daily life of the population, moving away from the emphasis on the biological causation of the disease health process[20].

Health education also has the capacity to promote greater involvement and approximation of users with health professionals. This capacity is an important bracing for these activities[9]. In order for educational strategies to achieve the expected results, it is necessary to create a bond between educators and learners, allowing for trust and respect, which subsidizes the reach of comprehensive and problem-solving care[17].

With regard to the responsibility of health education in the PHC, it is emphasized that health education is a collective construction, based on multidisciplinary and intersectoral work, seeking a more comprehensive and humanized care, aiming to guide the process of emancipation of the individual. Therefore, it should be accepted as a routine strategy, continuous, expanded and involving as many professionals as possible[21,19]. However, authors also show that these activities are commonly performed by NASF-AB and CHA professionals[22].

In the presented reality, health education was carried out with more emphasis by the multiprofessional residents, who mostly composed the NASF-AB. The *Residência Multiprofissional em Saúde* (Multiprofessional Residency in Health) represents a strategy to modify and organize services, health actions, training procesess, and educative actions, originating new work processes and contributing to improve the assistance in the FHS through the qualification of the care and strengthening of the SUS, besides providing comprehensive care to the user's health[23]. This training professional is able to overcome the fragmented view of health and consider the experiences of different professions in order to qualify the care of the user[24].

Regarding educational activities carried out by different professional categories, this partnership is seen as a positive point for the implementation of educational practices, making them more effective[9,25]. In addition, it is also observed the need to

strengthen the PHC's health promotion activities by the different professional categories, including those that make up the NASF-AB, making integrated work and sharing knowledge as well as the construction of new knowledge among the occupations[26-27].

Regarding the relevance of nurses, authors show that even the users themselves recognize the importance of this professional in the PHC, especially in relation to care and educational activities[28]. Therefore, the nurse has a unique role in the prevention and treatment of the health of the users within the FHS[28], besides presenting fundamental characteristics for the new way of seeing and doing health, being recognized as the professional staff to integrate the public policies of the team and the community, design health actions, as well as organize actions and services[29].

The literature reinforces the nurse's relationship with the users and the recognition of the importance of identifying the needs and singularities of the community to promote health education directed to the public interest and quality, generating reflections and helping the subjects' autonomy[7]. This professional must act in a multidimensional dimension, seeking to recognize in educational processes the innumerable tangles and ponder the teachings, in the acquisition of knowledge[30].

In this way, educative strategies carried out by the nurses are based on the construction of individual and collective knowledge, in the work process and in the health situation of the subjects. This favors the reflection of users, giving way to an ideal that the user is also responsible for their health[31].

In this perspective, the educational process must be rooted in any activity of health professionals, including care, in which the guidelines should be included and prioritized in order to promote more comprehensive care and improve health and quality of life of the population[28]. The moment in the office allows the creation of a dialogue between the user and professional, providing a more direct and subjective education[17], as well as promoting link building, qualified listening and focus on what is specific to that user[32]. However, these actions need not only happen in the office or health unit. Collective spaces within the community are unique environments and conducive to the execution of these activities, which can be offered through lectures and educational workshops, meetings and tours among other actions[7].

Although health education is a facilitating instrument for improving nursing care, this activity still faces a series of difficulties in the PHC, with emphasis on professional practices directed at the technical and biological dimension[32,17], which limit and decrease the execution of health education strategies in the routine of this level of care[24]. For professionals, it is difficult to prioritize work tasks, health promotion and disease prevention, which makes the latter activities less prioritized[33].

In addition, obstacles to the achievement of educational activities are mainly due to work overload, monthly goals to be achieved, lack of management support and motivation, lack of physical structure and material resources, lack of understanding of the population, leading to disinterested participation in actions, besides violence, are evidenced by these professionals as limiting educational strategies. These factors discourage professionals and create a barrier between the community and the health team, hindering the full development of professional nursing practices[14]. It is necessary to reinforce that health education should cover subjects, environment, culture, but also precedes a plan with the support of the manager and resources to be performed in the communities[34].

This reality emphasizes the need to valorize health education actions and to understand the importance of each professional category in these practices[19], which must assume the responsibility of an activity based on the clinical component[35]. In addition, there is a need for an organizational culture that promotes such activities, sufficient financial resources and, above all, appreciation of managers[36], through a reordering of the work process of the Family Health Teams[37]. Thus, the limitation on the part of the nurses with respect to the accomplishment of these activities is not a responsibility only of the professional, but of all involved in the process.

Study limitations

It is considered as limitations of the present study the impossibility of carrying out generalizations regarding the findings and characteristics of the selected methodological design. Another limitation is the fact that the collection instrument has not been previously validated, as well as the presence of multiprofessional residents in the selected BHUs, which is not a reality of all FHS. Further studies on the perception of the PHC team about health education practices are recommended, as well as the nurse's performance in the execution of educational activities.

Contributions of the sector of Nursing

The present study contributes to foster debates and reflections on health education as a practice of health promotion, as well as for the practice of Nursing, and in the training of nurses who view education as an essential practice with regard to comprehensive care.

FINAL CONSIDERATIONS

The objective of the study was reached, making it possible to understand the perception of the multiprofessional team about the practices of health education carried out in the PHC field. Health education was considered a responsibility of the entire PHC team. However, in reality, educational activities are carried out in a timely manner by social workers, including nurses, and multiprofessional resident professionals are the main executors of these actions. In the critical analysis of the speeches, the PHC multiprofessional team points out the nurse as manager of management and assistance actions and, to a lesser extent, educational actions.

In the field of health education, results showed that the nurse is considered an important educator. However, this professional is sometimes only the organizer of these moments, being executed under the responsibility of the other members of the team. In this context, nurses end up performing health education with greater emphasis in the moments of the nursing consultation. Thus, the group educational activities are carried out in a limited way due to the high demand of tasks and the low value of this professional and of the community for this facet of care.

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