

# The educational work of nurses in the Family Health Strategy: difficulties and perspectives on change\*

TRABALHO EDUCATIVO DO ENFERMEIRO NA ESTRATÉGIA SAÚDE DA FAMÍLIA: DIFICULDADES E PERSPECTIVAS DE MUDANÇAS

TRABAJO EDUCATIVO DEL ENFERMERO EN LA ESTRATEGIA SALUD DE LA FAMILIA: DIFICULTADES Y PERSPECTIVAS DE CAMBIO

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## ABSTRACT

The objective of this study was to understand the difficulties and perspectives on change that nurses have identified in developing educational interventions in the Family Health Strategy (FHS). This is a qualitative, descriptive-exploratory study. The data were collected with 20 nurses working in the FHS of the 10th Regional Health District of Paraná, by means of semi-structured interviews carried out in April 2010, which were subjected to content analysis. The results demonstrated that nurses face difficulties in developing health education strategies with the clients, healthcare team, and administrators, especially in regards to the lack of physical, material and financial resources. However, based on the difficulties they encounter, they seek alternatives to overcome them and suggest changes aimed at improving the delivery of primary health care to the population, particularly regarding educational practices.

## DESCRIPTORS

Health education  
Family health  
Public health nursing  
Primary Health Care  
Nurse's role

## RESUMO

Este estudo objetivou conhecer as dificuldades e perspectivas de mudanças que os enfermeiros identificam no desenvolvimento das ações educativas na Estratégia Saúde da Família (ESF). Trata-se de uma pesquisa qualitativa descritivo-exploratória. Os dados foram coletados junto a 20 enfermeiros que atuam na ESF, no âmbito da 10ª Regional de Saúde do Paraná, por meio de entrevistas semiestruturadas, no mês de abril de 2010, as quais foram submetidas à análise de conteúdo. Os resultados demonstraram que os enfermeiros enfrentam dificuldades no desenvolvimento da educação em saúde junto aos usuários, à equipe, aos gestores e quanto à falta de recursos físicos, materiais e financeiros. Mas, a partir das dificuldades sentidas, buscam alternativas diversificadas para superá-las e sugerem modificações visando à melhoria na atenção primária à saúde da população, principalmente, no que tange ao trabalho educativo.

## DESCRITORES

Educação em saúde  
Saúde da família  
Enfermagem em saúde pública  
Atenção Primária à Saúde  
Papel do profissional de enfermagem

## RESUMEN

Este estudio objetivó conocer las dificultades y perspectivas de cambio que identifican los enfermeros en el desarrollo de acciones educativas en la Estrategia Salud de la Familia (ESF). Se trató de investigación cualitativa descriptivo-exploratoria. Los datos se recolectaron a través de veinte enfermeros que actúan en la ESF en el ámbito de la 10ª Regional de Salud de Paraná, mediante entrevistas semiestructuradas, en abril de 2010, y fueron sometidos a análisis de contenido. Los resultados demostraron que los enfermeros enfrentan dificultades en el desarrollo de la educación en salud junto a los pacientes, al equipo, a los administradores y respecto de la falta de recursos físicos, materiales y financieros. Pero, a partir de las dificultades detectadas, buscan alternativas diversas para superarlas y sugieren modificaciones apuntando a la mejora en la atención primaria de salud de la población; principalmente, en lo que atañe al trabajo educativo.

## DESCRIPTORES

Educación en salud  
Salud de la familia  
Enfermería en salud pública  
Atención Primaria de Salud  
Rol de la enfermera

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## INTRODUCTION

In the attempt to put in practice a care model based on the principles of the Unified Health System (SUS), the Brazilian Ministry of Health (MS) proposed (in 1994) the Family Health Program (FHP), called Family Health Strategy (FHS) today, as a way to reorganize healthcare production, aiming to redirect care practice towards care focused on the family, understood based on its physical and social environment<sup>(1)</sup>.

The Family Health Strategy prioritizes actions to prevent, promote and recover people's health in a comprehensive and continuous way, developed through a minimal team, comprising a physician, nurse, nursing auxiliary or technician and Community Health Agents (CHA). In this new care model, the family health team, especially the nurse, assumes the challenge of delivering Primary Health Care based on educative actions, guided by the principles of health promotion, in which multiprofessional action is considered fundamental to improve health indicators and the population's quality of life<sup>(2)</sup>.

Health education presupposes a combination of opportunities that enhance health maintenance and promotion, understood not only as a transmission of contents, but also as the adoption of educative practices that seek the subjects' autonomy to conduct their lives. Thus, health education is but the complete practice of constructing citizenship<sup>(3)</sup>.

Health education refers to activities aimed at the development of individual and collective skills to improve quality of life and health. Hence, among FHS actions, educative actions emerge as a fundamental tool to stimulate each individual's self-care and self-esteem and, much more than that, of the entire family and community, promoting reflections that lead to modifications in users' attitudes and conducts<sup>(4)</sup>.

To establish health education in the health/disease process and satisfactory educative practice, it is fundamental to know the reality of the individuals one wants to involve in an educative action, as well as their potentials and susceptibilities, assessed in a holistic way. Hence, health education can and should be adapted to each individual's needs, interest and previous knowledge.

Therefore, some studies have focused on nurses' actions in this strategy; much remains to be done though. The innovative nature of the FHS evidences challenges related to the need to define the competences professionals need to develop their work, especially educative practice<sup>(5)</sup>.

In view of the relevance of the presented theme and interest in debating the educative process in the context

of the Family Health Strategy (FHS), this study aimed to get to know the difficulties and change perspectives nurses identify in the development of educative actions.

## METHOD

This descriptive and exploratory qualitative research is part of a broader research project entitled: *Care and educative activities in nurses' daily work in the Family Health Program – characteristics and challenges*, with funding from *Fundação Araucária*.

The research focus was the health education work FHS nurses develop in cities that are part of the 10<sup>th</sup> Regional Health District (RHD) in the State of Paraná, which comprises 25 cities and is headquartered in Cascavel. For the sake of this study, the cities in the 10th RHD were divided in five groups, according to population size: less than 5,000 inhabitants (six cities); between 5,000 and 10,000 inhabitants (ten cities); between 10,000 and 20,000 inhabitants (seven cities); between 20,000 and 35,000 inhabitants (one city); and more than 35,000 inhabitants (one city).

Eight cities were selected for the study; in the first three groups, which contained more than one city, two of them were randomly drafted and, in the other two groups, as there was only one city, these were selected. This was due to the fact that, as the cities display distinct population characteristics, the cities also display distinguish population healthcare capacities, which can influence the nurses' educative work.

All FHS nurses in the research cities could serve as informants, provided that they complied with the following inclusion criteria: being part of a complete FHS team and having worked in the same team for at least five months. Thus, out of 27 nurses working in the selected cities' FHS teams, 20 participated in the study, as four did not comply with the inclusion criteria, one was on holiday, one was on a health leave and one did not accept to participate in the study.

Data were collected in April 2010 through semistructured interviews. After the subjects gave their consent by signing the informed consent term, these were digitally recorded. A two-part semistructured script guided the interviews: the first contained objective questions about the subjects' sociodemographic profile; and the second open questions about health education involving the population. It should be highlighted that these interviews were previously scheduled by phone, according to each professional's availability.

For data analysis and interpretation, content analysis was used. Among different content analysis techniques, categorical analysis was chosen, which means dismem-

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bering the text into categories according to analogical groupings<sup>(6)</sup>. After categorizing the discourse, inferences were established based on the collected data, using the material available in scientific publications about educative work in the FHS for theoretical foundation.

The study was developed in compliance with the requirements of National Health Council Resolution 196/96, including Institutional Review Board approval from the University of Maringá (opinion No. 659/2009).

To distinguish the subjects and preserve their identity, informants were identified with the letter "E" followed by an Arabic numeral, indicating the order in which the interviews were held.

## RESULTS

Initially, the nurses' sociodemographic profile is described to get to know the study population. Then, the three categories that resulted from the content analysis process are presented: *Evidenced difficulties*; *Proposed alternatives*; *Suggested improvements*.

### Nurses' sociodemographic profile

Out of twenty nurses included in the study, the large majority was female (19), twelve were between 22 and 30 years old and the remainder (8) between 31 and 45 years of age. Twelve were married, six single, one lived with a fixed partner and one was divorced. Eleven interviewees did not have children and the others either one (4) or two (5) children.

Concerning professional education, most of them (13) had graduated from public universities. Graduation time ranged between five and 20 years (13) since graduation, while seven had graduated more recently, between one and four years. It was identified that the large majority (19) had taken a *lato sensu* graduate program in distinct areas, predominantly Public Health (12). When questioning them about the approach of health education at graduate level, a large part (15) answered that this was discussed, while four said that the theme was not mentioned during the course.

Work time at the unit ranged between five months and eight years. As for work conditions, 17 had passed a competitive examination and only three worked on a contract ruled by labor laws (CLT). Out of 20 nurses, only two had more than one employment, one in teaching and the other in hospital care. The predominant (11) family income was between six and nine minimum followed by three to five (5) and more than 10 minimum wages (4). The majority had between two and five people depending on this income.

### Difficulties evidenced

In view of FHS particularities, it is affirmed that health education is a fundamental action in the work process of the teams active in this strategy. Thus, based on the level of commitment and responsibility expected from family health team professionals, the desired level of community participation in health problem solving, broader understanding of the health/disease process, humanization of practices and search for primary health care quality, it is inferred that the model oriented towards educative practices is the most pertinent work for the context of FHS activities.

From this perspective, in the context of the themes studied, this reality is observed but the nurses, together with the interprofessional teams, face different difficulties to put educative work in practice.

In health education, in the individual as well as in the collective context, nurses working in the FHS are confronted with barriers, among which the main one is resistance to changes and acceptance of the new care model.

My main difficulty is with the population's culture because they, like, in general, there's still a lot of that curative things, medical appointment, physician and medication. So they do not attribute great importance to health education. So the population does not understand the goals of the FHP (E10).

In combination with the issue of acceptance and adherence to educative activities, there is difficulty related to the users' level of understanding of what is disseminated through orientations.

One of the difficulties I face is at the moment of health education, 'cause I observe limited understanding, no matter how hard I try to use a very simple, very accessible language, part of the people are illiterate, and many are elderly, so that makes it very difficult (E11).

One of the difficulties the nurses manifested with regard to the team refers to the professionals' lack of profile to work in the FHS perspective.

I face several difficulties, one of them I think is in the team because not all professionals have that FHP profile and not all of them participate in the activities. To give an example, the physician, he does not like and does not perform health education, he's still very cure-oriented and that makes things very difficult (E14).

Another difficulty the nurses appointed was the insufficient number of human resources in the FHS. All of the teams studied contained professionals from the minimal team but, in several cases (12), there were areas without Community Health Agent (CHA) coverage and very large areas for only one team, a fact that overloads everyone's work and turns into an obstacle, especially for educative work.

The fact of having a very big spontaneous demand, and also the lack of professionals, too much work, and a lot of bureaucratic work. And more than that, the professionals' turnover makes it very difficult to accomplish educative work(E5).

Among existing operational difficulties to put in practice educative work in the FHS, the management issue also exerts a strong influence on the accomplishment of these activities.

The main difficulty I face, I think, is the manager's lack of interest, they say that there's health education, but in practice there's not. They do not have the view of what the FHP is, the importance of educative work, they have a cure-oriented and medical view. So I think that, if we don't have support there, there are no conditions to work(E9).

The lack of or bad distribution of resources, whether physical, material or financial, also hampers health education. Among these, the nurses highlighted the issue of inadequate physical structure.

Ah, and besides one of the difficulties I face is that it's very agitated here because it's the central unit and the FHS is established here, because my team is allocated to this unit. So we do not offer educative activities, losing what the FHS would actually be, really underwhelming(E4).

Another important point the nurses mentioned and which limits health education actions is the insufficiency of material resources, which are equally responsible for hindering educative work.

And I think that there's some material missing here at the unit, because we know that there's a lot of material that could be purchased, that facilitate, that would be helping, because you get tired of just talking (...) (E7).

Besides, another problem the FHS nurses listed was accessibility, considering both the team for the entire coverage area of the Family Health Unit (FHU), which is relatively extensive, and essentially rural, and the users' access to the unit or the place where the educative action would take place.

Another difficulty is the locomotion issue, because we've got a car that stays more at the workshop than at the unit, because it's very old; so that also hampers work, and there's just one car to do everything(E13).

So our main problem here regarding health education is transportation, due to the fact that there's no bus line for them to come here, and it's often far; so that's the main problem for their non-adherence(E19).

It is highlighted that, in this study, a significant part of the teams (8) attend families living in the rural zone. This fact has made the population's access to the health unit more difficult, as well as the team's access to the family's houses or where the educative activities take place. This is especially due to distance and transportation difficulties, thus hampering community participation in health service actions.

### **Proposed alternatives**

Through the range of difficulties faced to develop health education activities with the population, the goal was to get to know the alternatives the nurses propose and use to overcome them.

With regard to people's cure-oriented thinking, it is evidenced that the inversion of the care model is hard to understand and that, probably, plenty of time will be needed for this to take place. Consequently, while the population's understanding is transformed, the nurses propose alternative options to develop health education actions.

As for culture, I think that the solution is to work with the children, with the young people, in schools, so that they become really more open. We try to show how important health care is, so that people get motivated, prevent, awake to the full exercise of citizenship and social control (...) (E2).

Another point the nurses raised as a bottleneck for educative work was people's level of understanding, which is considered a complicating factor for all health service actions as, if the users do not understand the information, it will be difficult for them to follow the advice and they will not be able to develop critical awareness about the importance of self-care and control on their own and community health. Therefore, to overcome this barrier, the nurses designated this proposal:

As for the literacy level, I try to talk so that they understand, not imposed, but dialogued, so that they start to trust us. And I think that the literacy issue too, that it would help a lot if the population would gain literacy(E6).

When penetrating into the work of an FHS team, the professionals need to know what philosophy rules the care model and put in practice all of their task. It is known, however, that all work is influenced by each professional's education and also determined by his/her profile and commitment. In view of this difficulty, in turn, the nurses opined:

With regard to the team's little participation, I think that educative work would be needed, better training, permanent education, health education courses. And also, the person would have to like the work. Now, to improve the physician's participation, I believe that preventive practice would have to be more valued in their education, and not just cure, because I think that, if they are not prepared for this, they will not develop it in their practice(E14).

Thus, it is highlighted that, if the staff does not act in accordance with the FHS' work proposal, this makes actions very difficult, mainly concerning education. Besides this difficulty, what aggravates this situation even further is not having an ideal number of participants in the team, as this entails a burden and, mainly, dissatisfaction and demotivation with work.



Regarding human resources, I believe that hiring more people would help a lot, especially CHA and nursing staff. And, to reduce the employees' turnover, I believe that wages would have to be readjusted, as they don't stay at the service because of dissatisfaction with the wages; so the salary and growth perspectives here are very bad(E5).

With regard to FHS management, the importance of having a person with a view on the health services and who knows their adequate functioning is widespread. In this respect, the respondents appointed:

So, first, I think that the managers would have to listen to us and understand our difficulties, that is, that they'd believe what we say and attend minimally to our requests. I consider that, if the managers knew our reality and the FHP goals, they would allocate resources to our work better (E20).

By identifying a range of difficulties in educative work with the population, the nurses propose alternatives that can improve the performance of health service supplies in the FHS context.

One issue which I think would make educative work in the FHP feasible would be its implementation at a specific unit for its coverage area, and that this unit would be well adapted; then we could better monitor the population, doing health education. As for materials, more financial resources would need to be available for health education(E8).

About the population's difficulty to access the health unit, or the places where educative actions take place, the nurses also proposed alternatives.

I believe that, if there were a transportation means for them to come here, that would help a lot and we'd have greater adherence to the group, a bus line for example(E19).

Although they cannot solve this problem, they can discuss the different strategies that could be adopted to solve this situation with the population, besides helping in the community's mobilization process to require this kind of service from responsible entities, which in this case would be the municipal governments and their legal representatives.

The nurses acknowledge alternatives that go beyond their possibilities, which mainly involve the availability of financial and material resources, so that the only role left for them is to demand these.

For the care issue, I think that a car would always have to be available for the team and in good conditions and which would get maintenance(E5).

### **Suggested improvements**

After identifying difficulties and possibilities to transform the reality of educative work in the FHS sphere, the nurses indicated some changes that are fundamental for health education to fully occur. Thus, based on the re-

ports, the main changes were listed, whether in the personal, professional or management context.

So I think that we always need to seek further knowledge and updates, studying, taking graduate programs(E12).

I think that there should be, like, more training from the secretariat and the regional health district for us, updates regarding the FHP and all programs, I believe that would help a lot(E16).

The professionals affirm that they need constant updates, through studies, readings, courses, which the entities responsible for the Family Health Strategy could make available, including the Municipal Health Secretariat, the Regional Health District and the Ministry of Health. In that sense, it is observed that the nurses recognize the importance of stable and durable updates, as they believe that education and training lead to professional commitment.

I think like, that the issue of health education would need to be more addressed in education already, so that the team would work together in daily work to put the FHP in practice. Therefore, everyone should be stimulated and trained to act preventively, so as to attend to FHP goals, which are pretty in theory, but have not been happening much in practice. But, in addition to all that, I believe that, to be a good professional and develop your work well, good will and commitment to work are fundamental(E8).

Besides personal and professional changes, in turn, the nurses affirm that one of the main modifications that should take place is related to the manager's view on educative work and the true goals of the FHS.

So I think that the manager should have a degree in health and fully understand what the FHP is, and that it weren't a political function in which they aim to get votes through curative actions, the number of medical appointments and specialized tests(E20).

## **DISCUSSION**

It is observed that many difficulties exist to work with the population, especially regarding prevention and health promotion, as people's thinking remains largely cure-oriented. Thus, for users and team members to value and accept educative work, everyone needs clear knowledge on FHS aims and work jointly to consolidate the proposed care model.

Users, however, essentially see Primary Health Care as individual and curative action, in which medication prescription is seen as the main concrete alternative to see to their health needs, and they are not perceiving the other activities, mainly educative work and group actions, as ways of improving and qualifying health<sup>(7)</sup>. Therefore, for the population to perceive the health system in a broader sense, above all, professionals need to believe and bet on these changes and on the benefits for the entire population's health.

For health service users to apprehend orientations and act in action planning together with the team, they need to effectively understand the knowledge shared, so as to understand the goal of educative actions.

Studies have been developed to identify health professionals' development of educative actions involving the community, many of whom have perceived that these actions are not performed frequently, mainly due to the disorganization of demand, users' low education level and the population's resistance against educative actions. Besides, for health education to be a reality in the FHS, all team members and especially the community need to know the goals of the strategy<sup>(8-9)</sup>.

The change in users' perception of the care model can be related to the culture constructed throughout history, in which health care was based on medical appointments and was mainly individual. Therefore, the entire health team needs to work to make users understand that health service delivery in the FHS is based on comprehensive health care, focused on prevention and health promotion. Working to change this conception among users represents an essential challenge for this strategy to achieve the expected success; in this case, the nurses affirm that working with children and young people can positively contribute to achieve success.

Although the reorientation of the care model, which the new FHS policy is part of, is a concrete proposal, in practice, it is still being consolidated and, thus, elements of both health care models coexist. At the same time, the idea persists in society in general that health services are associated with disease instead of health<sup>(10)</sup>. In different studies, including the present, however, professionals and teams' efforts are visible for the changes to occur and for the model based on disease prevention and health promotion to be consolidated.

To work on health education in the FHS, it is fundamental for professionals to know the reality of the population in their coverage area, its limitations and possibility, working in an ethical, creative, innovative and welcoming way, knowing how to deal with adversities. Many of the constraints on the performance of the educative actions discussed here, however, probably flee from health professionals' immediate control, in view of the macro-ideological nature of the issue<sup>(10)</sup>.

Team members often do not perform educative work because they do not have a profile based on the premises of the FHS, so that professionals display lack of interest and commitment to work and to the community's health conditions. For educative activities to be developed in a broad and qualified sense, all multiprofessional team members should be involved, in which each member can cooperate based on his/her body of knowledge.

In this perspective, a study developed in the interior of the Brazilian Northeast appointed the disarticulation

of health team members' knowledge on the theoretical, methodological and philosophical perspectives of the FHS as one of the determinants for the little involvement of the team's work with the educative area, resulting in a lack of integration between a team's practical actions and the educative dimension<sup>(11)</sup>.

This study is similar to the data found in literature concerning the physician's work, in which it is described that these professionals are unfamiliar with prevention and health promotion actions; therefore, they are unwilling to work with health education actions. Thus, it is highlighted that physicians, mainly newly graduated ones, report on the deficient focus on Primary Health Care and educative practices in their undergraduate program, and that they have little practical experience in the primary health care network, which has hindered their work in the FHS context<sup>(12)</sup>.

The nurses report that they are unable to dedicate themselves to health education due to the population's great curative demand at the units, insufficient staff in the team and, mainly, due to bureaucratic, coordination and unit management work, besides meetings at the Municipal Health Secretariat that end up taking most of their time and overburdening their daily work. They highlight that one of the main bottlenecks for the effective consolidation of the FHS is the quantitative and qualitative lack of professionals prepared to deal with the new tasks the care model requires<sup>(13)</sup>.

Concerning bureaucratic functions, it is affirmed that other professionals can perform these. On the other hand, when actions are educative and care-focused, they cannot be attributed to any team member who does not master this action. The main aggravating element in this situation is the team members' overload to accomplish bureaucratic tasks and the misplacement of professionals for care delivery to the population<sup>(14)</sup>.

The nurses highlighted that the existence of permanent education and course that stimulate the workers is one alternative to reduce difficulties in the development of educative actions and that, through these, professionals' interest in working on prevention and health promotion with users and their families can be aroused. Similarly, that professional education more oriented towards Primary Health Care and educative work would also have a positive influence on this behavior.

In this sense, permanent health education presupposes the needs for knowledge and structuring of educational demands generated in daily work, indicating the routes and clues for the education process, as an educative mode that targets the multiprofessional team, emphasizing actual health problems, whose goal is to transform technical and social practices<sup>(15)</sup>.

The lack and turnover of human resources have hampered work, especially educative work performance, as

most of the time is spent to attend to demands. Therefore, hiring adequate staff for each area, allied with their increased time working in the same team, would be fundamental to develop good work. It is highlighted that, when insufficient in number and qualification, a health team can negatively influence care delivery to families. This factor can also generate negligence in health actions, as available employees are often incapable of delivering care to the entire demand<sup>(16)</sup>. Besides, the turnover of multiprofessional team professionals is a very harmful factor for the effectiveness of the results expected in the FHS. Solving this problem represents the main challenge though, in view of the multiplicity of its causes<sup>(17)</sup>.

It is also highlighted that the professional satisfaction issue is not just based on the availability of ideal work conditions, but equally related to the wage issue. In other words, professionals work satisfied if their remuneration is in accordance with the function they perform.

The reports illustrate the nurses' efforts to perform educative actions and put the FHS policies in practice as, despite so many obstacles, they mention that they should always continue improving the knowledge inherent in their activities in this young and innovative strategy.

Thus, literature data ratify these reports, as health education can only be performed if professionals have knowledge and competences compatible with this practice. Hence, the authors affirm that collective health professionals' educative practice needs improvement and that permanent education processes need to attend to their needs<sup>(10)</sup>.

Concerning managers, based on the reports, it is perceived that, when they do not have a broad and adequate view of the FHS, they neither make resources available nor make efforts to accomplish health education, as it often does not seem to present imminent results to the community and may even threaten their position. Therefore, to work as health managers, knowledge on the care population's profile would be necessary; the needs the population presents; standards and laws ruling the FHS: human resource, physical and material needs to attend to the population covered, among others, according to the particularities of each region where the strategy is implanted<sup>(16)</sup>.

To work in a certain position, it is known that knowledge on its attribution and work reality is necessary. In this case, the nurses believe that, if the managers' view changes, if they start to understand the aims and reality of the FHS in each place, transformations will occur in the distribution of resource, consequently improving the entire team's work conditions, mainly concerning the development of health education.

As a part of the work process in the FHS, management activity is considered interdisciplinary action, in which technical, but mainly political determinations are present.

Within this perspective, managers need to understand the dynamics of the sociopolitical-economic relations present in the organization of the health service inside the work process<sup>(18)</sup>.

To perform their function satisfactorily, managers need to know the particularities of the health sector and the health care model. They should be trained for this function and their actions should not focus on satisfying political interests; if they do, health care may be impaired.

Literature data show that, because of its direct contact with the community, with its demands and religious, political, corporate and community leaderships, the FHS experiences intense proximity, which greatly exposes health service actors, making them susceptible to the local political process, which enhances a culture of exchange. And as the health area is sensitive in electoral terms, generating promises and votes, the local political power attempts to take hold of the FHS device as an exit to count votes. This fact should be assessed and reverted when thousands of people's living and health conditions are at stake<sup>(19)</sup>.

Concerning the lack of resources, it is highlighted that, for the FHS to be effective, an adequate space is needed to develop the work, especially health education. The Family Health Unit (FHU) can be allocated together with the Primary Health Care Unit (PHCU), but each in its specific environment.

It is highlighted that, due to the fact that the FHU and PHCU function in the same space, the population may not understand and be able to distinguish the differences between these services, which is a factor of constraint for the effectiveness of FHS policies, mainly with regard to education, prevention and health promotion actions for families and the entire community.

In view of all of the obstacles the nurses under analysis report, it is observed that their data are similar to other studies about factors considered as limits on health education practice in the FHS context. In this dimension, some authors guarantee that many difficulties exist concerning service structure, and that many of them directly affect work with the families. Among the difficulties, the following stand out: dislocation from the unit to the coverage area; coverage areas relatively distant from the unit; high number of teams allocated to the same unit; lack of a specific family health unit; precarious physical structure and material resources available at the units, among others<sup>(14)</sup>.

Educative work in the FHS and other team attributions can only be developed if an adequate work place is available with resources for this purpose. It is verified that, although the professionals acknowledge the importance of performing health education, they express the anxiety to accomplish work in the community that is more directed at the premises of the FHS, with a view to its strengthening and concreteness. At the same time, however, there seems to be a feeling that, in practice, no work conditions

are provided for the consolidation of this care policy and, consequently, for the reorientation of the health care model<sup>(10)</sup>.

In this study, it was evidenced that overcoming difficulties to develop educative work involves situations that go beyond nurses' professional framework. Hence, the team should inform managers about the importance of having transportation means available and in good conditions to perform work in this context, especially based on home care and educative actions in distinguished locations.

## CONCLUSION

Based on the present study results, it was evidenced that the nurses experience different bottlenecks in the development of health education, concerning users, multiprofessional team members, managers and the insufficiency of physical, material and financial resources, among which the following stand out: lack of acceptance and adherence to educative activities; curative culture; users' low education levels; accessibility of users and the team; great spontaneous demand; profile of team professionals; work overload; professional education; lack of permanent education; lack of resources; manager's view and lack of knowledge about the Family Health Strategy (FHS) policy.

## REFERENCES

1. Ermel RC, Fracolli LA. O trabalho das enfermeiras no Programa de Saúde da Família em Marília/SP. *Rev Esc Enferm USP*. 2006;40(4):533-9.
2. Brasil. Ministério da Saúde; Secretaria de Políticas de Saúde. Cinquenta milhões de brasileiros atendidos. *Rev Bras Saúde Família*. 2002;2(5 n.esp):1-80.
3. Pereira ALF. As tendências pedagógicas e a prática educativa nas ciências da saúde. *Cad Saúde Pública*. 2003;19(5):1527-34.
4. Machado MFAS, Monteiro EMLM, Queiroz DT, Vieira NFC, Barroso MGT. Integralidade, formação de saúde, educação em saúde e as propostas do SUS: uma revisão conceitual. *Ciênc Saúde Coletiva*. 2007;12(2):335-42.
5. Villas Boas LMFM, Araújo MBS, Timoteo RPS. A prática gerencial do enfermeiro no PSF na perspectiva da sua ação pedagógica educativa: uma breve reflexão. *Ciênc Saúde Coletiva*. 2008;13(4):1355-60.
6. Bardin L. *Análise de conteúdo*. Lisboa: Edições 70; 2008.
7. Sberse L, Claus SM.. O Programa Saúde da Família na ótica de trabalhadores e usuários de saúde. *Bol Saúde*. 2003;17(2):124-32.
8. Melo G, Santos RM, Trezza MCSF. Entendimento e prática de ações educativas de profissionais do Programa Saúde da Família de São Sebastião-AL: detectando dificuldades. *Rev Bras Enferm*. 2005;58(3):290-5.
9. Jesus MCP, Santos SMR, Amaral AMM, Costa DMN, Aguilar KSM.. Discurso do enfermeiro sobre a prática educativa no Programa Saúde da Família em Juiz de Fora, Minas Gerais, Brasil. *Rev APS*. 2008;11(1):54-61.
10. Silva CP, Dias MSA, Rodrigues AB. Práxis educativa em saúde dos enfermeiros da Estratégia Saúde da Família. *Ciênc Saúde Coletiva*. 2009;14 Supl 1:1453-62.
11. Silva CC, Silva ATMC, Losing A. A integração e articulação entre as ações de saúde e de educação no Programa de Saúde da Família - PSF. *Rev Eletr Enferm [Internet]*. 2006 [citado 2008 jul.7];8(1):70-4. Disponível em: [http://www.fen.ufg.br/revista/revista8\\_1/pdf/v8n1a10.pdf](http://www.fen.ufg.br/revista/revista8_1/pdf/v8n1a10.pdf)
12. Gonçalves RJ, Soares RA, Troll T, Cyrino EG. Ser médico no PSF: formação acadêmica, perspectivas e trabalho cotidiano. *Rev Bras Educ Med*. 2009;33(3):382-92.
13. Marques D, Silva EM.. A enfermagem e o Programa Saúde da Família: uma parceria de sucesso? *Rev Bras Enferm*. 2004;57(5):545-50.



14. Marcon SS, Lopes MCL, Lopes MB. Facilidades e dificuldades percebidas por enfermeiros na assistência à família. Online Braz J Nurs [Internet]. 2008 [citado 2008 jul. 7];7(1). Disponível em: <http://www.objnursing.uff.br/index.php/nursing>
15. Mancia JR, Cabral LC, Koerich MS. Educação permanente no contexto da enfermagem e na saúde. Rev Bras Enferm. 2004;57(5):605-10.
16. Lazzarotto EM., Roecker S, Ross C. Gestão por habilidades e atitudes: trabalho do enfermeiro na saúde da família. Cascavel (PR): Coluna do Saber; 2009.
17. Medeiros CRG, Junqueira AGW, Schwingel G, Carreno I, Jungles LAP, Saldanha OMFL. A rotatividade de enfermeiros e médicos: um impasse na implementação da Estratégia de Saúde da Família. Ciênc Saúde Coletiva. 2010;15 Supl 1:1521-31.
18. Passos JP, Ciosak SI. A concepção dos enfermeiros no processo gerencial em Unidades Básicas de Saúde. Rev Esc Enferm USP. 2006;40(4):464-68
19. Ximenes Neto FRG, Sampaio JJC. Processo de ascensão ao cargo e as facilidades e dificuldades no gerenciamento do território na estratégia saúde da família. Rev Bras Enferm. 2008;61(1):36-45.