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ORIGINAL ARTICLE

Concepts of health education by public health nurses

CONCEPÇÃO DE ENFERMEIROS DE UMA REDE PÚBLICA DE SAÚDE SOBRE EDUCAÇÃO PARA A SAÚDE

CONCEPCIÓN DE LOS ENFERMEROS DE UNA RED PÚBLICA DE SALUD EN EDUCACIÓN DE LA SALUD

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ABSTRACT

This qualitative study identifies the ideas regarding health education of 12 nurses who are part of the public health service of a city in the São Paulo countryside, and proposes a corresponding educational action. In this study, we used the methodology of action research. Data collection occurred in the second half of 2009 in the public health units of the mentioned municipality. Participant observation and interviews were implemented. The analysis and interpretation of data were conducted through categorization, based on the theory by Paulo Freire. As a result, the reductionism of health education in the pedagogical approach involving the transmission of knowledge was exposed, envisioning a biologicist tendency of academic training. However, in discussion circles, the awakening of political awareness related to the theme and the promotion of health was assumed. In conclusion, there is a need for changes in such training and for the facilitation of new modes of scientific production in the quest for social transformation.

DESCRIPTORES

Education; nursing
Health education
Public health nursing
Health promotion

RESUMO

Estudo qualitativo que objetivou conhecer as concepções de 12 enfermeiros assistenciais, que compõem a rede pública de saúde de um município do interior paulista, sobre Educação para a Saúde, e propor ação educativa. Utilizou-se da metodologia da pesquisa-ação. A coleta dos dados ocorreu no segundo semestre de 2009, nas unidades públicas de saúde desse município. Foram usadas as técnicas de observação participante e entrevistas individuais. A análise e interpretação dos dados foi feita por categorização, fundamentada na teoria de Paulo Freire. Como resultados, revelou-se o reducionismo da Educação para a Saúde na abordagem pedagógica que envolvia a transmissão de conhecimentos, contemplando uma tendência biologicista da formação acadêmica. Porém, nos círculos de discussão, presumiu-se o despertar de uma consciência política relacionada à temática e à promoção da saúde. Concluindo, apreendeu-se a necessidade de mudanças na formação, e de viabilizar novos modos de produção de ciência, na busca pela transformação social.

DESCRITORES

Educação em enfermagem
Educação em saúde
Enfermagem em saúde pública
Promoção da saúde

RESUMEN

Estudio cualitativo que tuvo como objetivo conocer las opiniones de 12 enfermeras, que representan la salud pública de un municipio en el Estado de São Paulo, en la educación para la salud, la educación y proponer acciones. Se utilizó la metodología de investigación-acción. La recolección de datos ocurrió en el segundo semestre de 2009, unidades de salud pública en el municipio. Hemos utilizado las técnicas de observación participante y entrevistas. El análisis y la interpretación de los datos se realizó de acuerdo a las categorías, en base a la teoría de Paulo Freire. Como resultado de ello, reveló el reduccionismo de la Educación para la Salud en el enfoque pedagógico que incluyó la transmisión de conocimientos, que comprende una tendencia biológica de la beca. Sin embargo, en círculos de discusión, se supuso el despertar de la conciencia política en relación con el tema y la promoción de la salud. En conclusión, se apoderó de la necesidad de cambios en la formación, y permitir nuevas formas de producción de la ciencia, la búsqueda de la transformación social.

DESCRIPTORES

Educación en enfermería
Educación em salud
Enfermería em salud pública
Promoción de la salud

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INTRODUCTION

The improvement and maintenance of health requires actions directed to the different aspects and complexities of life, a fact requiring the feasibility of educational approaches that promote health, both individually and collectively.

Thus, health promotion involves several human approaches that take organic aspects into consideration, but efforts are being made to overcome this context, with housing, psychological, environmental, social, cultural, and other aspects being introduced in relation to health. This is why it becomes important to understand the difficulties of health professionals in the everyday practice of health education. In turn, this requires appropriate training as well as the articulation between theory and practice[1-2].

Below, we present the definitions of processes that have sought to educate topics of health namely health education, education for health, and continuing education for health.

Historically, until the mid-1970s, health education was defined as those health education actions that are aimed at the presentation and adoption of new life habits by patients, incorporating a behavior that avoids diseases. The very name health education presented a framework that was focused predominantly on curing, at the expense of prevention and health promotion. This type of biologicist approach results in the fragmented care of human beings, focusing only on the disease and its biological aspects[3].

Such model of education and health care of a biomedical character do not always succeed because the difficulty of health institutions to be accessible at the primary care level, where demand is growing, still remains, making it a must to strengthen relations between the formal health system and the community[3-5].

Some of the features of such biomedical model include focus on curative aspects; gap between the knowledge and practices of the realities of individuals, both in education and in the area of health; weakening of the scientific dissemination and lack of educational interventions related to health and not to the disease and the patient; and knowledge, habits, and popular beliefs neither considered nor shared[3-5].

The paradigm shifts in attention and education that are aimed at health become more difficult when a deaf ear is turned to the needs and expectations of citizens, and actions are limited solely to therapeutic requirements. Professionals are unprepared for participatory work with the community because of the excessive specialization and crystallization of knowledge of the professionals, as holders of science and knowledge[5].

In the 1970s, health education began to undergo a change in terminology and was renamed *health education.* This change also represented a challenge in the context of the health promotion concept when the importance of encouraging individuals to assume greater control over their own health became evident. Thus, there was a need for the attainment and development of educational approaches that promote health comprehensively[5-7].

Health education is defined as the shift of a predominantly biological and curative focus to one of prevention and promotion of health, encompassing the various contexts (social, cultural, environmental, etc.) in which humans function and making it worthwhile to listen and to accept the reality of learners, thus predominating a health practice dimension that is subjective, humanized, and focused on the citizen. The Ministry of Health (MOH) has highlighted the unpreparedness of health professionals in dealing with such dimension[5-8].

Health education is defined as the shift of a predominantly biological and curative focus to one of prevention and promotion of health, encompassing the various contexts (social, cultural, environmental, etc.)...

This new paradigm converges with the works of Paulo Freire, which can contribute significantly to the education for health by increasing the possibilities of pedagogical conceptions and practices[9]. A review study of the publications of the MOH from 1980 to 1992 found that the central idea of the educational process in educational programs for health was based on Freire. Since the 1970s, these programs have been strongly influenced by Freire's thoughts and theory of libertarian education. Such programs evidence the change of the official discourse on health education, which changed from a traditional approach of imposing models to a more critical approach focused on community participation[9-10].

In 2009, the MOH created the National Policy for Continuing Education in Health to consolidate an integrated strategy for educational action in this area. The document criticizes the traditional model of education, in an attempt to break with the methodological process that reduces education to techniques that are disjointed from each other. It emphasizes the need for coordinated action to address comprehensive and complex problems, with a commitment to conduct learning in organizational and social contexts.

Continuing education for health must be integrated into the social, health, and service contexts, starting from the problems of everyday life; it should be reflective, participatory, perennial, and focused on joint construction of problem solving, considering that problems do not arise without the individuals who create them. It combines various moments and specific arrangements, aiming at a global project that organizes the development of institutional change of teams and social subjects and at the transformation of collective practices in pursuit of self-reflection and action research[11].

Faced with all these aspects that permeate this study, upon proposing a participatory action and consideration of the social context as described in the methodology below, these bring forth some considerations. As a science of human care, nursing must seek to improve itself in the institutions in which it operates and within the political, economic, and social relations it is involved, which affect the relationships that humans have with the world, including work and the ways of being and living. In teaching, we need to develop strategies that integrate the promotion of health as well as of the cultural, ethical, moral, and religious reinterpretation of the new millennium, with a view to a more humanized approach[12].

The present study determines the concepts concerning health education of nurses in public health of a city in the São Paulo countryside. The study involved working together on these concepts and perspectives, and offering educational activities that are to be jointly prepared and executed with the participants.

METHODS

This is a qualitative, descriptive, and exploratory study that uses the methodology of action research. It is part of a larger study that investigates the thoughts of nurses concerning health education among other issues, in order to encourage the construction of new paradigms related to the topics studied.

This study is oriented to answer the following question: What does health education mean to you?

To answer this question, it was considered that the action research would be the most appropriate investigative process, a methodology in which researchers coordinate with the participants to jointly construct perspectives on the theme. The horizontal nature of the methodological construction considers that the production of science cannot be vertical, but can be developed in conjunction with the participating social subjects, considering equally all the knowledge involved and enabling the understanding of social reality and the identification of their problems, even though the proposed educational activity is triggered by the researcher and jointly developed by all participants[15].

In this study, it is understood that health research is intrinsically a complex reality that involves biological, physical, psychological, social, and environmental aspects, and that the health-disease binomial is related to historical, cultural, political, and ideological burdens and cannot be reduced to numerical formulas or statistical data[13-15].

Action research, in turn, began with Lewin and Corey, North American authors of the 1960s who sought to approximate the dynamics of social practice with a theory of society. This line of thought proposed the accurate observation of the processes of social change, triggering reflection and the production of research aimed at social action and not just the production of books[16-18].

Between 1960 and 1970, another aspect to which this research is linked originated from the thoughts of Paulo Freire, educator and theorist, whose works had a strong, emancipatory, political nature and a liberating pedagogical proposal that sought the political transformation of the participants, involving them in the process of knowledge construction.

The present study was conducted based on the theoretical-methodological references of Freire, adapted by Bueno[15], and bounded by two phases: the first was a survey of socio-demographic data and the thematic universe from which generating themes were identified; the second was the execution of educational activities.

The techniques used for data collection were: 1) participant observation, with the field diary as an instrument for recording the data observed by the researcher, and 2) individual interviews, using as an instrument a questionnaire that contained questions about the data identification of participants and guiding questions about the theme in focus and was to be filled out by the participants.

The application of the described techniques allowed the immersion of the researcher in the complexity of the actual context, i.e., in the nurses' workplace, as well as the reconnaissance of their knowledge achieved academically, and their views, values, and beliefs derived from the daily practice on education for health. By merging these overlapping spheres in a continuum of reality, the problematizing view on which this research is founded has been supported.

The proposal of the study was to address only the nurses allocated to the public health service of a city in the countryside of São Paulo, with the criteria that the public sector contributes daily to the consolidation of the Unified Health System (SUS). The city chosen is located 450 kilometers from the city of São Paulo-SP and has approximately 40,000 inhabitants; its economy is based on agribusiness (the sugar and alcohol sector).

Since May 2006, the city has been entitled to full management control of Municipal Health. The municipal public health service has nine family health units, a basic health unit, a medical specialties outpatient unit, one emergency department (PA), and a Center for Psychosocial Care (CAPS). It also has a philanthropic hospital and a mental health outpatient unit (in which there are no nurses), the latter two not being part of the study.

All nurses allocated to the public health service of the city were invited to participate in the study, and all participants were considered to be representatives, in terms of this study. Inclusion criteria were: a) that the participants be part of public health services in order to assess the problems of this sector, b) that they give their consent for participant observation, and c) that they submit the questionnaire by the agreed deadline.

Thus, 12 nurses took part in the study; one nurse from a basic care unit refused to participate, one PA nurse was ill at the time of the study and could not participate, and the CAPS nurse did not meet the predetermined criteria. The research sites were all of the family health units, the outpatient medical specialties, the basic health unit, and the PA. Participants in this study were identified by the letter P followed by a number from 1 to 12 to preserve confidentiality and anonymity.

This study met the scientific rigor and ethical precepts required by the National Research Ethics Committee and was approved by the Research Ethics Committee of the Ribeirão Preto Nursing School, University of São Paulo (ethical process approval No.1077/2009). Upon agreeing to participate in the study, the nurses signed a Free and Informed Consent Form. Data collection occurred in the second half of 2009.

It is worth mentioning that at that time, the change (exchange) of municipal managers occurred.

Finally, the second phase (educational activity) was planned and executed from the listed generator categories/themes.

RESULTS

Most participants were female, married, and Catholic; half had graduated less than five years previously, three in the prior ten years, and three graduated more than 10 years before the study. Half were between 24 and 30 years old, three between 31 and 40 years old, and three between 41 and 50 years old. The period of training coincided with that of practice, and only one nurse had worked as a nursing assistant before graduating.

Their responses were grouped into six categories, according to group consensus: providing information; disease prevention and health promotion; correct use and structuring of health services; health autonomy; improved quality of life; and humanization and citizenship.

It is worth noting that the discussion of this study also refers to the data and impressions noted by the researcher in the field diary, which corresponds to the action research, considering that the researcher is part of the reality of those surveyed, conducts exchanges, and captures knowledge and experiences. No one type of data collection is predominant (i.e., not just the interview), with the intention of making the results more enriching.

Category 1: Provision of information

... providing information to the public... P1.

(...) informing the public... P2.

It is the teaching of educational measures... P3.

... enhancing the professional as well as directing the result to the customers... P4.

... transmitting knowledge to other team members and customers of the health unit P5.

... keeping up to date on issues related to the area... P9.

Category 2: Disease prevention and health promotion

... providing information to the people who lead to the promotion of health and disease prevention in the community P1.

... adopting and maintaining healthy living standards P2.

... teaching educational measures for the maintenance of health P3.

... aiming to use the technical-scientific knowledge for preventive action, not only

focused on disease but on the health of the individual P6.

... keeping up to date on issues related to the field, exchanging information and ideas with other professionals P9.

Category 3: Proper use and structuring of health services

Informing the public to correctly use the health services that are at their disposal P2.

They are means to structure and implement a health system P10.

Category 4: Health Autonomy

Developing in people a sense of responsibility for their own health... P2.

Category 5: Improved quality of life

... the foundation for the individual and his environment being able to live in harmony, consequently resulting in a better quality of life P7.

... is essential because it helps increase the quality of life of the population P11.

Category 6: Humanization and citizenship

Humanization; rights of all citizens P8.

DISCUSSION

Phase 1: The research phase: categories

Category 1: Provision of information

Predominantly, along the lines of health education, the concept of education for health reflects a discourse grounded in the traditional health education model. Education is defined as the act of enabling the provision of information and transmission of knowledge to the public and other professionals. It is inferred that these concepts are derived from the knowledge provided by academic training, which emphasizes the transmission of knowledge and information.

Generally (in half of the responses), when we analyzed only the responses of the participants, we had the

impression that knowledge was not constructed collectively, and popular beliefs, taboos, and prejudices were not considered, as would be according to the progressive and emancipatory contemporary educational model in the framework of education for health[19]. The discourse is focused on the professional as the main figure and holder of knowledge[9].

However, along the lines of current progressive education views as seen in the following categories, the responses of these same participants, paradoxically, are permeated by other viewpoints with regard to health care and the health education actions.

Category 2: Disease prevention and health promotion

In this category, albeit discreetly, the introduction of elements, such as health promotion and exchange of information, was clarified.

The responses reflect a discourse reasoned in the educational model and the attention to traditional health care, which preaches the so-called healthy living standards focused on disease [20-21]. The scientific literature reveals that historically, educational actions were intended to submit the patient to new living habits, in which changes in behavior that could prevent diseases should be adopted, focusing on the medical-biological knowledge and excluding the complex social factors that underlie the individual and collective life[5,21].

Category 3: Proper use and structuring of health services

In this category, we point out that in parallel to the written responses, which are discussed immediately below, during the participant observation, the nurses identified the difficulties at work when a health system is unstructured. This prevents them from meeting all the demands of the consultations even when users do not know how to use the services since they often seek immediate solutions, which, in the opinion of the participants, do not lead to any resolution. This aspect infers the need of awareness among users, professionals, and managers regarding the use of the available services and health actions since awareness results from the collective construction of knowledge[9].

Thus, it became clear that the proper use of health services and the structuring of the system are assigned to health education.

These responses converge with the precepts of the World Health Organization (WHO) and the MOH, which highlight that health education should involve workers and users together in pursuit of building concepts that support health practices improvements in a more comprehensive and integral manner[20-22].

Category 4: Health Autonomy

Although this category was based on the response of only one nurse, it was possible to conclude during the participant observation that most participants also considered that there was often no co-responsibility between healthcare professionals and users because according to the study participants, the user assigns the responsibility for their health to the professional. Participants considered the education/awareness of the assisted public difficult.

Therefore, in a timely manner, this category converges with the advocacy of the WHO concerning the promotion of individual and collective health. This occurs through educational strategies in health so that the subject may have autonomy and decision-making over his own health, which refers to the values of autonomy and solidarity and to the Freire universe wherein education is an instrument for the human being; as a result of the construction of knowledge, he can take responsibility for his own life[9,20].

Category 5: Improved quality of life

The aspect of improving the quality of life was associated with the goal of education for health.

Later, during the discussion panels, there was a rethinking of values and beliefs on the part of the participants with respect to this category since they realized that while they are professionals, they are also users of the health system, i.e., there has been awareness of their political and citizenship roles in the society. This again refers to the theoretical principles of Freire, who believes that above all, we are human beings with subjective needs. In this sense, it is understood that the theory (health for education) corresponds to everyday practice.

With respect to this category as in the Freire universe, the WHO conceptualizes the new framework of contemporary education to be represented in political practice, taking into account the daily life and its constituent elements between the world and the subject and shaping the collaboration and coordination between technical and popular knowledge. Thus, as a concept and practice, education for health would be an instrument of articulation between science and everyday life, based on values that seek social transformation, review, and emancipatory action, both of the attender and attendee[9,14-15,20].

Category 6: Humanization and citizenship

The participating nurses were interactive, building links with the attended community. In conversation, one participant correlated humanization and health education, binding it as part of humanized assistance, as a right of the population, and as a way to demonstrate citizenship.

The same was observed during the observation, at moments that were recorded in the field diary, in which nurses consider themselves as citizens and users of the health system. The presence of the investigator led them to wonder about the goals of health education. This fact converges with the methodology of research action because it motivates the surveyed person to take action with regard to the topic, promoting a critical awareness of reality[9,15].

Regarding this generator/category theme, the literature highlights that care technologies with a focus on educational actions are innovative and generate awareness of the people involved (educator and learners), which promotes humane care and the exercise of citizenship[2,8-9].

Phase 2: The action phase

The educational activity was conducted in four rounds of discussion meetings, lasting about two hours each, according to the contract agreed upon by the group. The participants gathered in a public school classroom during the school holidays.

The educational activity had two steps. First, we worked together with the participants on the problems and experiences identified as a result of professional practice related to the topic of health education and shared with the researcher. The second and third chapters of the book *Pedagogy of the Oppressed* by Paulo Freire were read and discussed, together with a scientific article on health education and a MOH document on the National Humanization Policy. We also sought to contemplate on the practical experience of the nurses concerning the issues and their applicability in the service.

The investigative and educational process, which was unique to the action research, generated controversy as part of the evaluation of the participants. We thus bypassed a spot assessment, performing a summative assessment that allowed a qualitative aspect and interaction of the participants[15].

Some participants stated that the new paradigms of contemporary education were *utopian*. However, on a positive note, they reported an approximation between the theoretical and practical approach of the study to their everyday professional life. They reported that they learned more about the topic, and if at first they were surprised at the introduction of educational activity in a study, they then identified it as a verbalization space with regard to the difficult moments of their daily work, providing the opportunity to meet and interact in an informal and relaxed manner.

From the perspective of the researcher, action research in terms of research and educational activities provided challenges related to the following: a) at the beginning of the research, the lack of motivation of some nurses to participate in the research (on the subject in focus) was noted as mentioned above, since the researcher was inserted in the actual context in which the research took place, with the participants conscious of his presence (the municipality went through a change in managers and, therefore, possible changes in working rules); b) the complexity of the generating theme, the relation of this topic with professional daily life during the participant observation, and the preparation of educational actions, as permeated by dialogue, caused greater flexibility, constant adjustments in discussion circles (educational activity), and less prior control of actions; c) assessment was considered a process and not a usually punctual procedure.

Thus, it is understood that the factor enriching this research was not the immediate change of conceptions or behaviors of participants in the professional area because this was not educational but a reflection generated by both parties (the researcher, who was immersed in constant self-criticism, and the participants). The very presence of the researcher in the field, bringing the discussion of the guiding theme in focus, led participants to a number of issues, perspectives, and new approaches to the problems identified and experienced in that group, from the exchange of experiences and knowledge, dialogue, and exercise of criticism, which lead to awareness and questioning, and following the assumptions of progressive pedagogy of Freire.

CONCLUSION

This study made it possible to verify how health education was explained by a group of nurses who work in the public health service in a city in the countryside of São Paulo. Upon the beginning of the study, the municipality was passing through a change of managers, which required several adaptations of the participants to the workplace and may have caused a lack of motivation of the participants, a fact that is considered a limitation of the study.

The categorization of the responses revealed the reductionism of health education, which is renowned as one of the professional imparting knowledge and reflects the traditional way of work of the participants. The difficulty in conceptualizing the theme while inserted into new paradigms (education for health) results from the biologicist tendency that is centered on the medical model of health care and the knowledge acquired in the academic environment, which highlight the need for further adjustments in the training of these professionals.

Aspects such as co-responsibility, humanization, citizenship, quality of life, and autonomy with regard to health were discussed by this group of nurses in discussion circles and educational activities. Presumably, there was an awakening of political awareness related to the subject of the study and promotion of health, with recognition of the gap between theory and professional practice, or between academic knowledge and professional routine.

Studies that deal with education for health aimed at these professionals are still lacking. It is understood that the education pathway as proposed in this study is an ongoing, participatory, horizontal, circular, and dynamic process and requires awareness among the educators who believe that changes are needed.

The facilitation of educational activities is actually science, nonetheless, and the permanence of old problems of society in the XXI century makes it necessary to break with traditional modes of knowledge production and go in search of new horizons and new paradigms in science production, in the quest for social transformation.

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