http://dx.doi.org/10.1590/0104-07072017000260016

HEALTH EDUCATION DEVICE: REFLECTIONS ON EDUCATIONAL PRACTICES IN PRIMARY CARE AND NURSING TRAINING

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ABSTRACT

Objective: to construct reflections on the health education device, considering the educational health practices developed in the Primary Health Care and in the nursing training.

Method: this is a reflexive essay based on the concept of a device proposed by Deleuze.

Results: we unraveled the lines of visibility and enunciation, the lines of force and the lines of subjectivity of the health education device, highlighting the real wills implied in the modes of subjectivation produced in this device. The lines of visibility and enunciation of the health education device are located in visible, discursive, hybrid and contradictory fields, which at times are built from a specific notion of health and education and at different times by another notion. In this device, subject-educator and subject-learner are objects of the lines of force; they recompose and are recomposed by modulations configured in the spheres of power and knowledge. The projects of each subject can predispose lines of fracture and lead to productions of subjectivities that leave the powers and knowledge of a device to reinvent themselves in another device. In order to predispose lines of fracture in the health education device, it is necessary to design training processes that allow nurses to take creative positions in their health education practices.

Conclusion: this essay allowed us to expand the conceptual territories involved in educational practices in health and nursing education, opening the way to understand the subjectivation processes in health education.

DESCRIPTORS: Education in health. Primary health care. Nursing. Public health. Education in nursing.

DISPOSITIVO EDUCAÇÃO EM SAÚDE: REFLEXÕES SOBRE PRÁTICAS EDUCATIVAS NA ATENÇÃO PRIMÁRIA E FORMAÇÃO EM ENFERMAGEM

RESUMO

Objetivo: construir reflexões sobre o dispositivo educação em saúde, considerando as práticas educativas em saúde desenvolvidas na Atenção Primária à Saúde e a formação em enfermagem.

Método: trata-se de um ensaio reflexivo que se ancora no conceito de dispositivo proposto por Deleuze.

Resultados: desenredamos as linhas de visibilidade e de enunciação, as linhas de força e as linhas de subjetividade do dispositivo educação em saúde, destacando as vontades de verdade implicadas nos modos de subjetivação produzidos nesse dispositivo. As linhas de visibilidade e de enunciação do dispositivo educação em saúde instalam-se em campos visíveis, discursivos, híbridos e contraditórios, que em dados momentos se constroem a partir de uma noção específica de saúde e de educação e em momentos diferentes por outra. Nesse dispositivo, sujeito-educador e sujeito-educando são objetos das linhas de força; recompõem e são recompostos por modulações configuradas nas esferas do poder e do saber. Os projetos de cada sujeito podem predispor linhas de fratura e conduzir a produções de subjetividades que saem dos poderes e dos saberes de um dispositivo para se reinventar noutro. Para predispormos linhas de fratura no dispositivo educação em saúde, é necessário concebermos processos formativos que possibilitem que as/os enfermeiras/os assumam posturas criativas em suas práticas educativas em saúde.

Conclusão: este ensaio permitiu-nos ampliar os territórios conceituais implicados nas práticas educativas em saúde e na formação em enfermagem, abrindo caminhos para compreendermos os processos de subjetivação que se movimentam no campo da educação em saúde.

DESCRITORES: Educação em saúde. Atenção primária à saúde. Enfermagem. Saúde pública. Educação em enfermagem.

DISPOSITIVO DE EDUCACIÓN EN SALUD: REFLEXIONES SOBRE PRÁCTICAS EDUCATIVAS EN LA ATENCIÓN PRIMARIA Y FORMACIÓN EN ENFERMERÍA

RESUMEN

Objetivo: construir reflexiones sobre el dispositivo de educación en salud, considerando las prácticas educativas en salud desarrolladas en la Atención Primaria y la formación en Enfermería.

Método: ensayo reflexivo que se ancla en el concepto de dispositivo propuesto por Deleuze.

Resultados: desenredamos las líneas de visibilidad y de enunciación, las líneas de fuerza y de subjetividad del dispositivo de educación en salud, destacando las voluntades de verdad implicadas en los modos de subjetivación producidos en este dispositivo. Las líneas de visibilidad y de enunciación del dispositivo de educación en salud, se instalan en campos visibles, discursivos, híbridos y contradictorios, que en dados momentos se construyen a partir de una noción especifica de salud y educación en momentos diferentes por otra. En este dispositivo, el sujeto-educador y el sujeto-educando son objetos de las líneas de fuerza; recomponen y son recompuestos por modulaciones configuradas en las esferas del poder y del saber. Los proyectos de cada sujeto pueden predisponer líneas de fractura y conducir a la producción de subjetividades que salen de los poderes y de los saberes de un dispositivo para reinventarse en otro. Para predisponer líneas de fractura en el dispositivo de educación en salud, es necesario concebir procesos formativos que posibiliten que las/los enfermeros asuman posturas creativas en sus prácticas educativas en salud.

Conclusión: este ensayo nos permitió ampliar los territorios conceptuales implicados en las prácticas educativas en salud y en la formación en enfermería, abriendo caminos para comprender los procesos de subjetivación que se mueven en el campo de la educación en salud.

DESCRIPTORES: Educación en salud. Atención primaria de salud. Enfermería. Salud pública. Educación en enfermería.

INTRODUCTION

The educational practices in health, which are fundamental in the working process of Primary Health Care (PHC) teams, are mainly developed on the basis of information and persuasion transmission[1] emphasizing on illness.[2-5] These practices are based on the traditional health education model, characterized by the increase of information about the health problems and by the recommendations of behaviors considered right or wrong.[6]

Although the traditional model predominates, it is possible to identify educational health practices in PHC that seek to overcome it through the use of different pedagogical strategies, such as art and theater.[7] These practices aim at overcoming the approach focused in pathology and in transmission of information, considering the dialogue and the subjectivity of the individuals in the educational process. We understand pedagogical strategies as the conditions that allow accessing teaching and learning processes, including tools that favor the expansion of knowledge and production of meanings.

Although we observe the existence of educational health practices that seek to overcome the traditional model, they often emphasize pedagogical strategies and their results, giving little or no visibility to the method. That is, the theoretical assumptions underlying the health education practices developed in the PHC are often obscure.[8] By means of the obscurity of the method, the use of differentiated pedagogical strategies, such as art and theater, does not necessarily imply the commitment to the dialogical method and to the development of the subjects' autonomy.[9]

These considerations suggest that the health education practices developed in PHC, in general, remain based on the traditional model, seeking to advocate the adoption of behaviors considered healthy, although they are often called dialogical.[10] They perpetuate a hegemonic rationality between professional-educator and user-learner, which define good habits of life and contribute to the constitution of an identity matrix that, guided by the discourse of autonomy, emphasizes the management of bodies and self-care.[11]

In the nurse's training processes, professional often responsible for health education practices in PHC, the traditional model of health education is also reproduced. Among nursing students, conceptions focusing on biomedical knowledge and transmission of information predominate. Often, training is limited to curricular experiences that seek to equip students for educational health practices based on scientific knowledge and individual behavior changes.[12]

In addition to the nurse's training in the academia, discussions about the relevance of Continuing Health Education (CHE) are considered for the consolidation of a teaching and learning network at work,[13] with pedagogical strategies development that provide the exercise of creativity.[14] However, in general, CHE actions, when performed, are insufficient, unsystematic, also based on the biomedical model and carried out through vertical pedagogical strategies, decontextualized from the professionals' reality.[13-14]

Then, for us, the nurses' training process in the academy and at work guides them to an operation operated with the thought defined as the will of truth (the will to produce certain modes of subjectivation from health behavior practices that control subjects based on behaviors defined as healthy). Modes of subjectivation are the heterogeneous processes and practices through which people relate to themselves and others in a certain way.[15]

Therefore, health education has a mode of production of subjects guided by discursive practices activated, produced and reiterated by the nurses. In health educative practices, discourses and senses are mobilized to explain and detail certain ways of experiencing life habits, constituting specific modes of subjectivation, based on normativity and homogenization.[16] This approach refers to the concept of device, with a process structure of a massive individuation through the provision of homogenized modes of existence.[17]

In this sense, there is the production of certain modes of subjectivation in the Health Education Device, understood here as a multilinear operative setting[18] with nurses belonging to and acting in the PHC. The literature had no studies proposing to map the concept of a device in the context of health education, which ratifies the purpose of this article to construct reflections on the Health Education Device, considering the health education practices developed in the PHC and nursing training. This is a reflexive essay based in the concept of a device proposed by Deleuze[18] and which attempts to map the health education device, highlighting the real wills implied in the modes of subjectivation produced in educational practices in health and in the currently training of nurses.

DEVICE: CONCEPTUAL APPROACH

Developed by Foucault, the concept of a device is defined as "... a decidedly heterogeneous set that encompasses discourses, institutions, architectural organizations, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, and philanthropic propositions. In short, the said and the not said are the elements of the device. The device is the network that can be woven between these elements".[19:244]

Analyzing Foucault's work, Deleuze defines the device as a multilinear operative setting composed of lines of a different nature, namely: lines of visibility and lines of enunciation, which make see and say; the lines of force, invisible, that move the seeing and the saying; and the lines of subjectivity, which act upon themselves. These lines have no constant coordinates and, therefore, mapping a device does not guarantee the existence of a previous form that could be assumed; on the contrary, the device needs to be reworked and produced incessantly.[18]

Health education device: unraveling the lines of visibility and enunciation

The first two dimensions of a device are the so-called lines or curves of visibility and lines or curves of enunciation. The devices are machines to make see and make speak. The visibility is made by lines of light and each device has its light regime, that is, its way that the light falls and distributes the visible and the invisible. The enunciations, in turn, refer to lines of enunciation, which are curves that distribute differential positions of the elements of the device.[18]

These lines point to what is visible and what is sayable of the device, which, in itself, refers to the existence of something invisible and unspeakable. They produce discursive objects that, in the field of health education, allow subject-educator and subject-educator to enter the order of discourse, acquiring different forms, colors and details. However, the curves of visibility cannot be confused with the images and scenes immediately seen, and the lines of enunciation do not refer immediately to the sayings, spoken or written.[16] Thus, the curves of visibility do not refer to the specific form to see a subject. This is because the subject is a place in the visibility and the ways of seeing are previous to the subject's individual will, that, here, is object. Regimes of enunciation are not merely what is spoken, but what is taken as possible and justifiable to speak. Multiple and proliferating enunciations find conditions to enter the order of discourse.[16] From these lines, for example, the subject-educator and the subject-learner in this or that discourse the makes them objects are determined. Around the forms of visibility and enunciation, continuous health education practices are constituted.

When we unraveled the lines of visibility and enunciation of the health education device, we noticed they are installed in visible, discursive, hybrid and contradictory fields, which at a given moments are constructed from a specific notion of health and education and in different moments by another notion. They are notions that are embedded in discourses and educational practices in health. In general, by dismantling these notions it is possible

to highlight at least two concepts of health, education and health education. Although different connections between these concepts are possible, we can infer two health-education-education-in-health conceptual connections observable in the health education device.

A first health-education-education-in-health conceptual connection in the health education device re-establishes the Cartesian logic, which, drawn from the 17th century on, surrounds the mechanicism, biologicism and dualism notions and contributes to the epistemological orientation of health education practices. The concept of health, in this logic, is understood as the absence of disease[20] and leads to the classification of human states as healthy or diseased, based on an objective analysis,[21] in addition to defining a systemic classification of diseases in an orderly and systematized manner.[20] This system is arbitrary at its departure because it neglects in a regulatory way any difference that is not part of a privileged structure, besides being relative because it can function according to the desired accuracy.[22] Therefore, the concept of health as an absence of disease leads us to legitimize a way of acting in health that seeks the common about the difference and that defines something (or someone) by the limit of what distinguishes it, by what the other is not.

In the conceptual connection articulated to this concept of health, we emphasize the traditional notion of education, which presupposes a pedagogical practice in which the educator places himself/herself as superior subject, who teaches a spectator. The educational objectives are to fill the learners with content, making deposits of communication, and creating mechanisms that lead them to reproduce past knowledge as absolute truth.[23] In this notion of education there is a subordination of singularity to ways of the same and the similar, of the analogous and the opposite. It favors appropriateness, rather than production, and logical formalism, rather than the condition of possibility to produce truths. Here, education presupposes a moralizing, transcendent, individual ontology. It is the denial of the singular life; the realm of dualisms, models, discipline, and control.[24]

In a linear coherence with these two concepts of health and education, a detachable health education perspective is the one that refers to prescriptive practices of behavior. In it, the learner is the individual that lacks in health information, that is, as someone who needs to learn about healthy habits. This perspective is currently considered ineffective and does not promote the development of critical and conscientious subjects of their reality and of their health, capable of thinking and promoting changes in their daily lives and ways of being and of producing health.[23]

This first health-education-education-in-health conceptual connection bases the educational practices in health developed under close connection with biomedicine, which has a generalizing character and, therefore, does not deal with singularities. The biomedical model aims at objectifying the body, lesions and diseases, based on its truths and its instrumental theory. Legitimating of their truths and their theory, in society, in universities, in hospitals, leads to the deprivation of other discourses and other practices in everyday life, giving the other specialist control over the bodies. This is why the learner is considered the one who lacks knowledge and experience, with needs to be regulated in his or her health habits.[11]

Health education, understood in this conceptual connection as an instrument of reproduction of scientific discourse, tends to delineate means of massive individuation, without considering the singularities, the different modes of existence and health production. Focusing on the analysis and prescription of behaviors, it prioritizes control and stabilized configurations that, based on biomedical discourses, rely on learning as an operation of information accumulation, which denies affections, involved actors and other ways of seeing and living the world.[25]

Another possible and justifiable health-education-education-in-health conceptual connection in the health education device goes back to an epistemological rupture that deterritorializes the essentially biologicist, mechanistic and dual conception of health, education and, consequently, health education. In this connection, health is a right of all and the duty of the state, in a conceptual proposal constituted as an effect of sanitary reform. Resulting from the forms of social organization of production, it is considered for the development of strategies that seek to reduce vulnerability and to create situations that defend equality and social participation.[26]

This concept of health creates openness to consider different determinants of the health-disease process, such as violence, unemployment, underemployment, gender inequalities, lack of basic sanitation, inadequate and/or absent housing, difficulty access to education, hunger, disordered urbanization, air quality and threatened water, as well as the historical-social and generational influences

of communities. When compared to the concept of previous health (absence of disease), we realize that the health-sickness binomial is also present here, not as a submission from one to another, but with an intimate relationship between the health and disease terms.[27]

In the health education device, associated with this concept of health, it is also possible to highlight the notion of education based on the dialogical construction of knowledge. In this notion, education promotes autonomy of the subject and his/her conscience as a critical citizen of the world. The educator is a mediator of the process of knowledge elaboration and the learner is an active participation of the teaching and learning process. Both participate together in knowledge production.[23]

This perspective is based on the problematizing and liberating conception of education developed by Paulo Freire, who conceives the learner as a historical and social being, aware of his/her transforming power in the world. Freire believes that teaching is not limited to the transmission of knowledge, but involves the creation of possibilities for the development of criticality. It grows in a dialogical process between educators and learners and is capable of favoring the expansion of analytical capacity and a more active, participative and autonomous positioning of individuals.[23]

In this conceptual connection, related to the last concepts of health and education, we emphasize health education under the social participation focus, which considers the shared construction of the knowledge that underlies people's worldviews. Pedagogical strategies create possibilities to awaken in the subject critical and reflexive thinking, in order to lead him/her to build knowledge about their life and health, through the articulation between technical and popular knowledge.

Currently, many studies base on this perspective of health education. They are developed to address specific topics, such as asthma,[28] tuberculosis[29] and cardiovascular diseases,[30] with delimited publics, as users of psychoactive substances[30] and with sex workers.[31] These findings allow us to say that there is an approach, above all, to themes linked to diseases, with defined publics based on common components. We infer a reference to modern science, which establishes a precision cut, a delicate and methodical operation that ends in the delimitation of a certain apprehensible and controllable object. The cut and the precision give a taxonomy to life phenomena and to subjects, making them amenable.[27] The approach to diseases as themes of educational practices in health implies a centrality in what is placed in a legitimate and ordered system of diseases, which often limits the subject who has the disease and defines the habits so far considered correct. As for the defined publics, there is an attempt to think of them from an identity notion, which seeks the common about difference and that identifies people to then group them, seeking standardization by classification.

As such, we consider that, although they are often based on a dialogical perspective, educational health practices, in general, contribute to the constitution of certain modes of subjectivation, considering specific groups and favoring certain autonomy. This autonomy translates into new modes of conduct and subjectivity control, with the imposition of prescriptions and blaming discourse, from which the subject becomes ill for not making choices as prescribed.[11] In this perspective, autonomy in educational practices in health suggests the standardization, without the openness to the different ways of being, feeling and knowing.[32] We can then consider that health education in PHC, guided by autonomy discourse, constitutes a standardizer device, captured by a biomedical logic, little inclined to people's singularity.

Parallel to the lines of enunciation, talking about the lines of visibility, what is inscribed in scenes of health education is also important. Scenes such as chairs arranged linearly and in circles, groups arranged in circles and in rows, posters arranged on the walls and manipulated by the participants, the educator at the center, in the circle, for example, point to the impure and hybrid notions observed in the lines of enunciation. This is because the different spatial configurations, that is, the different modes of organization of the elements that compose the space, regarding limited and open spaces, spatial configuration that makes easier or opens to the bodies and reveals the traditional and/or dialogues methods,[33] and corresponding pedagogical strategies, such as exposure and/or conversation.

Highlighting, for example, the organization of chairs arranged linearly or in circles, common in educational practices in health, it is important to map under what conditions of luminosity these scenes happen.[18] The arrangement of chairs in rows is considered a traditional organization, in which the fixed, linear position constitutes an arrangement of people in collective units accessible to constant vigilance. Through the rows, all eyes facing forward, confronting directly the neck of the colleague and

finding only the eye of the educator, the action of the gaze establishes the discipline (observation is a domination strategy). Dialogic pedagogical proposals often use the circle arrangement to exclude the interaction of the educator's direct control. It is a counterpoint to the traditional organization and opens the possibility for all to express their opinion and to be heard.[33]

While these spatial dispositions reflect their intentions, we may consider that there is nothing inherently liberating in the circles and nothing inherently oppressive in the traditional rows. On the one hand, the circle may require more self-discipline among learners, because they take responsibility for their behavior. On the other hand, the partial privacy allowed by the rows, in which one is under surveillance, may disappear as the learners are also under the other's colleagues supervision A learner who prefers not to express himself/herself is less self-evident when all the chairs face forward, just as a student who is shy, for example.[33] In turn, these aspects invite us to analyze and question relationships of power, which refers to what is unspeakable and invisible in the device: the lines of force.

Health education device: unraveling the lines of force

Third, a device has lines of force. These lines confirm curves of visibility, and the enunciation schemes outline their forms and paths. The lines of force set the back and forth between seeing and saying, intersecting things and words, passing through every part of the device. They are invisible and unspeakable lines. They closely relate to the dimension of power, since they fix the games of power and the configurations of knowing that are born from the device and that condition it.[18]

In the health education device, subject-educator and subject-learner are objects of the lines of force; they recompose and are recomposed by modulations configured in the spheres of power and knowledge. If health education is a domain to be developed, it is attributed to deceptive relations and actions of power that launch ever more insightful techniques of discursive knowledge and procedures.[16] In the process of producing subject-educator and subject-learner a discursive multiplicity plays with differentiated power strategies and with different purposes, such as control and dependence. Therefore, it is pertinent to show which relationships of power health education integrates around itself.

Unraveling the lines of force of the health education device is to ask what science/biomedicine says about health education, that is, what effects of truth can be captured in the produced speeches, but that is not all. It is also questioning why health education is adopted as a health practice.[16] Considering the lines of enunciation and visibility, when we think of the effects of truth that can be understood, there seems to be a tendency for health education practices to reproduce elements of biomedicine. The functionalist essence of health and health education prevails as the one that emphasizes the prescription of habits considered healthy, that do not incorporate the symbolic and subjective aspects and the ways of being and living of the individuals.

These aspects point to the rationality of medicalization, understood as the increasing expansion of biomedical interventions by (re-)defining human experiences and ways of being as medical problems.[34] This rationality reveals the power of medicine as an integral part of disciplinary power in society. In the disciplinary society, a set of devices of knowledge and power is based on the permanent vigilance and the normalization of behaviors. The disciplinary power materializes in the bodies of the people individualized by disciplinary techniques, potentializing their usefulness, their abilities and their income. In order for this disciplinary power to be exercised, it is only necessary that the persons submitted to it know that they are supervised or potentially watched.[35] Along with this technique of power, the power of the norm arises, which leads to the standardization of conducts from the disciplines that evidence a regime of truth.[36]

Although prevailing medicalization reveals disciplinary power, current health education practices are both an expression of disciplinary power and biopower. Biopower is a technology of power that, unlike disciplinary power, does not intervene in the individual, in the individualized body, but intervenes in the collective phenomena that can reach the entire population. Both technologies of power coexist in the same time and space, with the norm as a common element between discipline and regulation, which can apply to a body that wants to discipline and/or to regulate a population. The coexistence of these technologies originates the society of normalization, where the norm of discipline and the norm of regulation occur, and then, individual and population, body and life, individualization and massification coexist.

The current biopolitical society is inscribed in the register of the society of control. The emergence

of the society of control implies a range of modifications, such as the replacement of the school by the permanent formation, the examination by the continuous control. The more contemporary expressions of power develop variable geometries, sometimes invisible, conform with new control(actor)s. The imposing architectural structure of the confinements pulverizes into ultra-fast forms of outdoor control.[38]

In this direction, health education practices can become surveillance strategies that limit individual freedoms depending on how they are developed (in a medicalization of life discourse), or can be shaped under other, more silent and invisible control strategies (which work under the surface). At the same time, health education as an individual practice places the subjects under constant surveillance and, as a collective practice, controls, regulates and standardizes behaviors considered healthy.[37]

It is important to distinguish, in any and every device, what we are and what we are no longer (what is archive) of what we are becoming (what is current).[18] We denote that the updating of the health education device tends to point to an open and continuous control, in which the notion of power involves less discipline and more action that is exerted on another action, although there is still a predominance of educational health practices that limit the individual's freedoms through the discipline. The exercise of power does not act directly and immediately on others: it is an action on conduct. In this displacement, updating the device tends less to produce docile and passive subjects, giving space to the "active" subject who is able to take care of himself/herself.[11] Thus, the lines of subjectivation that compose and cross the health education device get closer.

Health education device: unraveling the lines of subjectivity

Finally, the lines of subjectivity of the device. They are those that act upon themselves and affect themselves. The line of subjectivity is a process, a production of subjectivity in the device: it is to be done, as far as the device allows or makes it possible. It is a line of escape, a line that escapes the other lines. It is neither knowledge nor a power, but a process of individuation that concerns groups or persons, which escapes established forces and established knowledge.[18]

As previously mentioned, updating the health education device tends to active subjective formations. In this direction, self-management, self-government of bodies and self-care in health are emphasized as elements of autonomy, contributing to the formation of new identity matrices, such as the constitution of active subjects.[11] In the neoliberalism perspective, the subject's freedom is a condition for its subjection, because the full exercise of authority presupposes the existence of a free subject. Practices of freedom that materialize in active forms are strategies for the autonomization of societies (such as changes in lifestyles) guided by a set of rules, standards and expert advice. More freedom and more autonomy also mean more government (control of conduct) and more citizenship means even more regulation.[11]

However, this whole process happens with resistance. Resisting gives conditions of possibility to escape. It is through the line of escape that new configurations of regimes and new forms of production of subjectivities are outlined. The projects of each subject can predispose lines of fracture and lead to productions of subjectivities that leave the powers and knowledge of a device to reinvent in another device, under other forms that are to be born. One can then watch the performance of lines of creativity, or update.[18]

Thinking about the lines of creativity or update of the health education device, it is important to emphasize that the training of healthcare professionals, in particular the nurses, has been configured as a relevant field of resistance against other modes (creative or updated) to produce health, including health education. This is because the professional training in the health area is still guided by a pedagogical conception centered on contents, hierarchizing the diseases in biological criteria and dissociating clinical and political criteria.[25]

In order to predispose lines of fracture in the health education device, other ways of doing health education that invite people to draw lines of escape, invent other ways of existence, and produce other ways of subjectivation are necessary. Formative processes should enable professionals, especially nurses, to take creative positions in their health education practices. Let us not think about what it is or what it should be, but what education can do: seek power by raising questions, investigating realities and questioning landscapes in the perspective of learning about oneself, environments and professional powers.[25]

Therefore, one must understand learning as an inventive activity, belonging to the world of movements, which includes affections and supposes activity of the actors involved. The invitation is to divest

ourselves of the prearranged fixed territories in order to rely on an education that encourages thinking, inventing and experimenting. In the case of training processes for nurses, we can develop pedagogical projects that amplify acts of thinking, learning and knowing about the performance. We believe in the potentiality of pedagogical strategies that allow the contact with alterity and the production of difference-in-us, that allow us to be affected and create conditions for a concept and an affection to constitute territory in ourselves and in an environment.[25]

CONCLUSION

Disentangling the health education device allows us to expand the conceptual territories involved in health education practices developed in the PHC and in nursing training. It opens the way for us to understand the processes of subjectivation in the health education field, mobilizing us to perceive the speeches, the visible scenes and the games of power involved, as well as the reproductive and inventive possibilities that can grow between Professionals-users-teachers-undergraduates.

Acknowledgements

We acknowledge the Foundation for Research Support of the State of Minas Gerais (FAPEMIG) for the support.

REFERENCES

1. Pinafo E, Nunes EFPA, González AD, Garanhani ML. Relações entre concepções e práticas de educação em saúde na visão de uma equipe de saúde da família. Trab Educ Saúde. 2011 Jul-Out; 9(2):201-21.
2. Díaz-Cerrillo JL, Rondón-Ramos A. Design of an educational tool for primary care patients with chronic non-specific low back pain. Aten Primaria. 2014 Feb; 47(2):117-23.
3. Braschinsky M, Haldre S, Kals M, Lofik A, Kivisild A, Korjas J, et al. EHMTI-o259. Demonstrational project: to develop, implement and test an educational model for better headache-related primary health care. J Headache Pain. 2014 Sep; 15 Suppl 1:D3.
4. Garcia-Ortega I, Rodriguez J, Escobar-Martinez A, Kutcher S. Implementing an educational program to enhance identification, diagnosis and treatment of adolescent depression into primary care in Guatemala. Fam Med Medical Sci Res. 2013 May; 2(1):1000104.
5. Chamberlain C, O'Mara-Eves A, Oliver S, Caird J, Perlen S, Eades S, et al. Psychosocial interventions for supporting women to stop smoking in pregnancy. Cochrane Database Syst Rev. 2013 Oct; (10):CD001055.
6. Fernandes MCP, Backes VMS. Educação em saúde: perspectivas de uma equipe da Estratégia Saúde da Família sob a óptica de Paulo Freire. Rev Bras Enferm. 2010 Jul-Ago; 63(4):567-573.
7. Uchôa AC. Experiências inovadoras de cuidado no PSF: potencialidades e limites. Interface (Botucatu). 2009 Abr-Jun; 13(29):299-311.
8. Gazzinelli MF, Souza V, Fonseca RMGS, Fernandes MM, Carneiro ACLL, Godinho LK. Educational group practices in primary care: interaction between professionals, users and knowledge. Rev Esc Enferm USP. 2015 Abr; 49(2):284-91.
9. Carneiro ACLL, Souza V, Godinho LK, Faria ICM, Silva KL, Gazzinelli MF. Educação e promoção da saúde no contexto da atenção primária à saúde. Rev Panam Salud Publica. 2012 Fev; 31(2):115-20.
10. Oliveira RSG, Wendhausen ALP. (Re)significando a educação em saúde: dificuldades e possibilidades a estratégia saúde da família. Trab Educ Saúde. 2014 Jan-Abr; 12(1):129-47.
11. Renovato RD, Bagnato MHS. Práticas educativas em saúde e a constituição de sujeitos ativos. Texto Contexto Enferm. 2010 Jul-Set; 19(3):554-62.
12. Colomé JS, Oliveira DLLC. Educação em saúde: por quem e para quem? A visão de estudantes de enfermagem. Texto Contexto Enferm. 2012 Jan-Mar; 21(1):177-84.
13. Silva JAM, Peduzzi M. Educação no trabalho na atenção primária à saúde: interfaces entre a educação permanente em saúde e o agir comunicativo. Saúde Soc. 2011 Out-Dez; 20(4):1018-32.
14. Abrahão AL, Merhy EE. Formación en salud y micropolítica: sobre conceptos-herramientas en la práctica de enseñar. Interface (Botucatu). 2014 Abr-Jun; 18(49):313-24.
15. Foucault M. O sujeito e o poder. In: Dreyfus H, Rabinow P. Michel Foucault: uma trajetória filosófica para além do estruturalismo e da hermenêutica. Rio de Janeiro (RJ): Forense; 1995. p. 231-49.
16. Marcello FA. O conceito de dispositivo em Foucault: mídia e produção agonística de sujeitos-maternos. Educ Real. 2004 Jan-Jun; 29(1):199-213.
17. Leonardi EFR, Antoun H. A agonística entre dispositivo de visibilidade e modos de subjetivação no blog da Galera Capricho. Cultura Midiática. 2012 Jul-Dez; 5(9):1-12.
18. Deleuze G. O que é um dispositivo? In: Balibar E, Deleuze G, Dreyfus H, Frank M, Glücksmann, et al. Michel Foucault, filósofo. Barcelona (ES): Gedisa; 1999. p. 155-63.
19. Foucault M. Sobre a história da sexualidade. In: Foucault M. Microfísica do poder. Rio de Janeiro (RJ): Graal; 2000. p. 227-43
20. Pratta EMM, Santos MA. O processo saúde-doença e a dependência química: interfaces e evolução. Psic: Teor e Pesq. 2009 Abr-Jun; 25(2):203-11.

21. Almeida Filho N. O que é saúde? Rio de Janeiro (RJ): Editora Fiocruz; 2011.

22. Foucault M. A palavra e as coisas. São Paulo (SP): Livraria Martins Fontes Editora; 2007.

23. Freire P. Pedagogia da autonomia. São Paulo (SP): Paz e Terra; 2009.

24. Kohan WO. Entre Deleuze e a Educação: notas para uma política do pensamento. Educ Real. 2002 Jul-Dez; 27(2):123-30.

25. Ceccim RB, Ferla AA. Educação e saúde: ensino e cidadania como travessia de fronteiras. Trab Educ Saúde (Online). 2009 Nov-Fev; 6(3):443-56.

26. Horta NC, Sena RR, Silva ME, Oliveira SR, Rezende VA. A prática das equipes de saúde da família: desafios para a promoção de saúde. Rev Bras Enferm. 2009 Jul-Ago; 62(4):524-9.

27. Costa ML, Bernardes AG. Produção de saúde como afirmação de vida. Saúde Soc. 2012 Out-Dez; 21(4):822-35.

28. Cano FG, Dastis BC, Morales BI, Manzanares TML, Fernández GA, Martín RL. A rondomised clinical trial to evaluate the effectiveness of an educational intervention developed for adult asthmatics in a primary care centre. Aten Primaria. 2014 Mar; 46(3):117-39.

29. Sá LD, Gomes ALC, Carmo JB, Souza KMJ, Palha PF, Alves RA, et al. Educação em saúde no controle da tuberculose: perspectiva de profissionais da Estratégia Saúde da Família. Rev Eletrônica Enferm. 2013 Jan-Mar; 15(1):103-11.

30. Abreu RNDC, Sousa AM, Dias LM, Almeida GH, Diógenes MAR, Moreira TMM. Educação em saúde para prevenção das doenças cardiovasculares: experiência com usuários de substâncias psicoativas. Espaço Saúde. 2014 Jul-Set; 15(3):13-21.

31. Godinho AS, Menezes RAO, Barbosa FHF, Sacramento BP, Silva KA, Slob EMGB. Educação em saúde para profissionais do sexo: impacto na mudança de comportamento. Ciência Equatorial. 2013 Jul-Dez; 3(2):2-9.

32. Ceccim RB. "Um sentido muito próximo ao que propõe a educação permanente em saúde"! O devir da educação e a escuta pedagógica da saúde. Interface (Botucatu). 2007 Mai-Ago; 11(22):345-63.

33. Gore JM. Foucault e educação: fascinantes desafios. In: Silva TT, organizador. O sujeito da educação: estudos foucaultianos. Rio de Janeiro (RJ): Vozes, 2011. p. 9-20.

34. Tesser CD. Medicalização social (I): o excessivo sucesso do epistemicídio moderno na saúde. Interface (Botucatu). 2006 Jan-Jun; 10(19):61-76.

35. Foucault M. Microfísica do poder. Rio de Janeiro (RJ): Graal; 2004.

36. Foucault M. Em defesa da sociedade. São Paulo (SP): Martins Fontes; 2005.

37. Silva KL. Promoção da saúde em espaços sociais da vida cotidiana [tese]. Belo Horizonte (MG): Universidade Federal de Minas Gerais, Programa de Pós-Graduação em Enfermagem; 2009.

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Recived: march 07, 2016
Approved: august 23, 2016