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ORIGINAL ARTICLE

CONCEPTIONS AND PRACTICES OF HEALTH EDUCATION: NURSES' PERSPECTIVE OF THE FAMILY HEALTH STRATEGY

CONCEPÇÕES E PRÁTICAS DE EDUCAÇÃO EM SAÚDE: PERSPECTIVA DE ENFERMEIROS DA ESTRATÉGIA SAÚDE DA FAMÍLIA

CONCEPCIONES Y PRÁCTICAS DE EDUCACIÓN PARA LA SALUD: PERSPECTIVA DE ENFERMEROS DE LA ESTRATEGIA DE SALUD DE LA FAMILIA

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ABSTRACT

Objective: to analyze the conceptions and health education practices from the perspective of nurses of the family health strategy. ***Method:*** qualitative study, which data were collected from semi-structured interviews with 13 nurses in a city of Minas Gerais (MG), Brazil and analyzed by content analysis. ***Results:*** health education is predominantly designed from the perspective of group mode and guided by the traditional pedagogy. The nurses, in the activities conducted for their daily work, linking the human, material and physical structure as limiters and/or enhancers to their education, recognize educational practice. ***Conclusion:*** concepts and nurse's health education practice show that the educator representation still presents itself far from their professional identity as it is anchored in external elements to them so that they can be effective in the routine of health services. ***Descriptors:*** Nursing; Health Education; Family Health; Qualitative Research.

RESUMO

Objetivo: analisar as concepções e práticas de educação em saúde sob a ótica de enfermeiros da Estratégia Saúde da Família. ***Método:*** estudo de abordagem qualitativa, cujos dados foram coletados a partir de entrevista semiestruturada, com 13 enfermeiros de um município de Minas Gerais (MG), Brasil e analisados pela Análise de Conteúdo. ***Resultados:*** a educação em saúde é predominantemente concebida na perspectiva da modalidade grupal e pautada na pedagogia tradicional. A prática educativa é reconhecida pelo enfermeiro nas atividades que realiza em seu cotidiano profissional, atrelando os recursos humanos, materiais e a estrutura física como limitadores e/ou potencializadores do seu fazer educativo. ***Conclusão:*** as concepções e práticas de educação em saúde do enfermeiro revelam que a representação de educador ainda apresenta-se distante da sua identidade profissional, uma vez que se ancora em elementos externos a ele para que possam se efetivar no cotidiano dos serviços de saúde. ***Descritores:*** Enfermagem; Educação em Saúde; Saúde da Família; Pesquisa Qualitativa.

RESUMEN

Objetivo: Analizar las concepciones y prácticas de educación para la salud desde la perspectiva de las enfermeras de la Estrategia Salud de la Familia. ***Método:*** estudio cualitativo, cuyos datos fueron recolectados a partir de entrevistas semiestructuradas con 13 enfermeras en una ciudad en Minas Gerais (MG), Brasil y se analizaron mediante análisis de contenido. ***Resultados:*** La educación sanitaria es predominantemente diseñada desde la perspectiva del modo de grupo y guiadas por la pedagogía tradicional. La práctica educativa es reconocida por la enfermera en las actividades desarrolladas en su trabajo diario, la vinculación de los recursos humanos, materiales y estructura física como limitadores y/o potenciadores a su educación. ***Conclusión:*** conceptos y práctica de educación sanitaria de la enfermera educadora muestra que la representación sigue presentando lejos de su identidad profesional, ya que está anclada en elementos externos a la misma de manera que puedan ser eficaces en la rutina de los servicios de salud. ***Descriptores***: Enfermería; Educación en Salud; Salud de la Familia; Investigación Cualitativa.

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INTRODUCTION

The search for the operationalization of the doctrinal principles of the Unified Health System (SUS) - universality, comprehensiveness and equity - led the Ministry of Health to an attempt to reorganize the healthcare practice, culminating in the creation, in 1994, of the Family Health Program (FHP), currently called Family Health Strategy (FHS). Its core is the assistance to families, perceived from the environment where they live, focusing on health promotion and health surveillance, in order to minimize the vulnerability of individuals/families/communities to diseases, enabling higher quality of life to the population.[1]

For meeting that new way of looking at health care model, it is necessary that the FHS professionals invest in tools that enable emancipatory practices among the population, aiming at the population's empowerment in health care. In this regard, there are educational activities that must be developed grounded in dialogue and exchange of experiences, promoting the enhancement of knowledge of educating and providing tools for its autonomy and for the transformation of their reality of life and health.[2]

Despite having as main objective giving the population the starring role of their health, empirically, educational practices anchor in biologicist and prescriptive vision, favoring the knowledge of health professionals at the expense of popular knowledge. That means an education guided by the transmission of knowledge, relying on the informational communication model, what Paulo Freire called banking education.[3]

In line with the exposed, studies show that health professionals tend to focus on the technical knowledge to the detriment of the involvement of users in production steps, that is, they perform educational activities in a vertical, unilateral and linear way, not stimulating the individual's role and insertion in the process of elaborating his/her own care. In addition, there is the commitment of the individual's emancipation, curbing his/her ability to overcome the political and social dependency. [2,4]

Based on the empirical evidence of the practice and those already described in the scientific literature, the following questions guided the research: what is the conception that the FHS nurses have on health education? What health education practices do they perform in their professional routine? What are the limits and potentiality evidenced by nurses in relation to educational practices?

Thus, this study aims to analyze the conceptions and practice of health education from the perspective of nurses working in the Family Health Strategy.

METHOD

A qualitative study, as it seeks to analyze the nurse's concepts and practices in relation to health education. The qualitative study works with the universe of beliefs, values and attitudes of subjects inserted in a given social reality, in which the human phenomena are. It allows, thereby, capturing the experience of reality, through discussion, analysis and attempt to solve a problem extracted from real life.[5]

The research scenario were the Primary Health Care Units (PHCU) of a city located in the Zona da Mata area of Minas Gerais. According to the census conducted by the Brazilian Institute of Geography and Statistics (IBGE) in 2010, the mentioned city had a total population of 72,200 inhabitants, with 64,300 living in the urban area and 4,900, in the rural area.[6] All its PHCU work in the logic of the FHS, totaling 14 health units and 15 family health teams.

The 15 nurses working at the Family Health of the mentioned city were invited to participate. The study included those who agreed to participate voluntarily, certified by their signatures on the Informed Consent Form (ICF), previously developed by the researchers. Two nurses did not participate in the study: one refused to participate and there was difficulty in scheduling with the other, totaling 13 participants.

Data collection occurred in September and October 2013, being the interviews previously scheduled by phone, according to the nurses' availability, and held at the health unit facilities where participants worked. For data collection, one used a semi-structured interview, combining open and closed questions.

To preserve the anonymity of the participants, they were identified with the letter N (nurse) accompanied by the corresponding number of the interview, as follows: N1 to N13. The following questions guided the interview: What do you mean by health education? What educational practices you carry out in your working context? What facilities and difficulties do you find when performing them?

Before responding the open questions, participants answered questions to

characterize them according to age, gender, marital status, professional training (including postgraduation), time working at the unit and type of employment.

Data were organized into categories and subcategories from the main ideas contained in the statements of the respondents and analyzed according to the Content Analysis Technique of Bardin. This technique bases on the following stages: pre-analysis, material exploration and treatment of results, inference and interpretation.[7]

Initially, a floating reading of the interviews was conducted, followed by exhaustive reading, adding deeper understanding of speeches against the studied phenomenon. Later, one proceeded to the theme selection, which consisted of identifying the units of meaning, or semantically similar elements, for further categorization and analysis.[7] The literature related to the theme guided the interpretation of the data.

The research was in accordance with the ethical standards established by Resolution 466/2012 of the National Health Council (CNS)[8], obtaining a favorable opinion from the Ethics Committee on Human Research of the Federal University of Viçosa (UFV), registered under n. 412,815.

RESULTS

The study participants were between 28 and 44 years, 11 women and two men. Regarding marital status, eight were married, three were single, one was divorced and one was a widower. With regard to vocational training, 11 graduated in private schools. The time elapsed after the completion of the undergraduate course ranged from two to ten years. Among the interviewees, nine were specialists in Family or Public Health.

The time working at the unit ranged from one month to three years and seven months, with an average work time of two years. All nurses were hired and three worked concurrently in another job in the nursing area, two in hospital care and one was a Professor.

The nurses' statements has allowed the emergence of two major categories: "Conceptual assumptions of Health Education" and "Health Education in the FHS routine". It is noteworthy that the first category of the study unfolded in two subcategories, called "Educational Methods" and "Methodological Conceptions".

♦ Conceptual assumptions of Health Education

Regarding the way the nurses perceive health education in their professional routine, they stated understanding it as an activity that takes place in individual or group mode. In relation to methodological conceptions of health education, it was evident they bring concepts that can translate it as authoritarian or dialogical practice.

♦ Education Methods

Nurses associated health education predominantly to group mode, basing on that perspective to exemplify their conceptions of educational practices:

> It's working with educational group [...] the same here, we have groups for childcare, for children aged zero to five years, hypertensive and diabetics. (N4)
>
> For me, health education is performing educational groups. (N6)
>
> They are group activities. It is more this kind of approach. (N13)

Another way to understand the health education is from the perspective of their actions in the FHS routine. In this sense, nurses understand that the educational practices pervade all their activities in that scenario, with emphasis on home visits and nursing visits:

> [...] I think we perform health education every time. There is no specific moment for that [...] it's daily, every day, every time. (N7)
>
> Health education, for me, is every time. During a nursing consultation, a home visiting [...] it doesn't have to exist only in groups. It's possible to educate during all the attendance to the patient. (N13)

In addition to health education modalities, nurses brought in their speeches elements that enable identifying how they conceive health education in their professional routine.

♦ Methodological Conceptions

Among the meanings of health education, nurses perceive it, predominantly, as an activity guided by the method of knowledge transmission, centered on technical and scientific knowledge at the expense of knowing the user/family/community:

> *Health education, for me, is to show people what it's the best for them [...] to be able to pass on knowledge for them [...] that most of people have lots of doubts about everything. (N3)*
>
> *[...] the key for everything is the information, the knowledge [...] we have to acquire it first, for, then, to pass on for the users (N5)*
>
> *Another way of conceiving health education, although expressed by the minority of nurses, is to understand it anchored in dialogue, being held in the user's knowledge*

as protagonist of his own teaching-learning process:

For health education, we need to speak the public's language. It's no use speaking the language from professional to professional. (N12)

For me, education is to allow the community, the subject, to become also responsible for their health, so that they have a stake and understand both the benefits as the harms it can cause to their health. It's putting them as subject of their own health. (N13)

In addition to health education concepts brought by nurses, it was possible to identify how they operationalize that practice in their professional routine, presented in the second category of this study.

♦ Health Education in the FHS routine

When asked about their practices of health education in the context of the FHS, the nurses brought elements that enabled them to list the educational activities carried out by them. Added to this, they demonstrated experienced limits and potentialities in their routines, which interfere positively and/or negatively on the performance of educational activities.

The nurses' conceptions on health education unfold in the practices they perform in the contexts in which they operate. Among the educational activities they reported performing, there is the health education at school, the waiting rooms, nursing consultations and, with greater expressiveness, educational groups:

We develop educational activities at school [...] we are doing a calculation survey on Body Mass Index to know who are obese, who are underweight [...] catch people before they get sick. (N1)

[...] We do educational groups [...] usually hypertension and diabetes [...] we also make pregnant group. (N11)

We do education in groups [...] of hypertension and diabetes, for example. (N12)

I think all the time through the waiting room, even through a screening during the reception [...] during a preventive consultation and in some specific groups, a group of physical activity, a pregnant group, a childcare, hypertensive and diabetic group. (N13)

For the operationalization of educational activities, nurses reported enabling and hindering elements in the context in which they operate, which interfere greatly in the realization of health education in their daily work.

Among the aspects that facilitate such practice, participants pointed out the bargain, team motivation, people's adherence, the support of graduate students, professional training for health education and the presence of suitable materials and physical infrastructure resources:

You have to have an attractive, have a snack. Giving away a freebie [...] it makes it easier. (N2)

The staff involvement [...] all the staff here helps, especially the doctor who is very involved [...] I think the only facility we have is this. (N3)

[...] The population's adherence, I think it makes it easier. (N7)

Students are very helpful [...] For example, to work with hypertensive and diabetic groups [...] the nutrition student talks about nourishment [...] there are students of Physical Education that talk about physical activity [.. .] and the Nursing and Medicine students talk about the pathology of diabetes and hypertension. (N9)

The staff is very motivated. That helps. (N10)

[...] Having the trained professional to address. Having the proper place, the available material at hand, got it? To address the issue that we program. So, I think those are the facilities. Having support. (N12)

Regarding the difficulties when performing the educational activities, nurses brought elements opposed to those that facilitate, such as non-adherence of the population, lack of staff motivation/ involvement, inadequate physical infrastructure, lack of human and material resources:

Look, the difficulty rally is to summon the population so that they participate, a frequent participation. [...] The difficulty really is to make them participate in groups. (N2)

[...] We are interested in doing so, but we don't because of the location and the materials we need [...] we don't have even a chair for people to sit [...] (N3)

[...] We need people to help and we do not have such support, for example, a physical education teacher, or an intern, we don't have yet [...]. Our physical structure is also precarious. This makes it very difficult [...]. (N4)

We lack our own headquarters [...] a place to make educational activity [...] we do out there, but when it's too hot, it is impossible to get out there because of the tile [...] (N6)

We do not have a suitable space to make educational meetings [...] we do it in the space outside the unit, but it is bad [...] we try to do with what we have [...]. (N9)

> *Lack of supplies [...] often lack pamphlet, lack informative material, we have to provide it all. (N11)*

In addition to those mentioned aspects, nurses pointed out that a major complicating element is the overload of the care and management activities they perform in the context of the FHS, unfolding in lack of time for planning and carrying out the educational activity:

> *[...] We have to serve and have to do the bureaucratic things [...] often, there is no time for educational activities [...] it's what hinders the most. (N5)*
>
> *Lack of time makes it very difficult [...] I think the HFP nurse has a lot of paperwork, a lot of paperwork to move, sometimes he gets a little time. (N7)*
>
> *A major barrier is the time [...] I have to do a lot of paperwork [...] How do I get time to plan a health education? [...] it's too much work for a single person; there is too much paper for a person to take over [...]. (N9)*
>
> *We do not have time because we have to do everything [...] there is not much time to make groups, which are very important, but sometimes, that gets overlooked. (N11)*

A nurse pointed out the population's education level as a complicating factor in health communication, relying on the understanding that the user is the one who needs to understand the technical and scientific discourse of the professional, and not the opposite way:

> *[...] The greatest difficulty is the users' educational level [...]. When you get to guide a person with a higher educational level is easier. We go straight to the point, speaking words she already knows the meaning. The thing flows. With the user who does not have that degree of intelligence, it gets too difficult. (N1)*

DISCUSSION

The nurses who participated in this study outlined, in their speeches, how they conceive educational practice in the context of the FHS. In this sense, they commonly perceive it as an activity that takes place in group mode, corroborating the literature.

Study conducted with nurses working in primary care in the city of Uberaba, Minas Gerais, pointed out that they predominantly associated health education with lectures and groups, reinforcing a vision still strongly present, not only in common sense, but also among health professionals.[9]

Although less significant, some participants conceive that educational practice can also be performed at the individual level, involved in activities in the primary care routine, especially in home visits and nursing consultations.

In this context, one can see health education as an integral practice that can be carried at all times and spaces, understood as an activity that focuses on the interaction between different knowledge and emphasizes the link with the community.[9]

This conception, although not portraying a vision of common sense and being timidly expressed in the nurses' speeches, deserves to be strengthened, since the health educator position is not restricted to nurses' specific terms and activities at PHC.

With regard to methodological strategies for health education, there was predominance, in the statements, the relationship between education and the transmission of knowledge. The literature confirms that finding, when showing that the traditional model still appears as the more deeply rooted in the design of health education by nurses.[1]

Predominantly, the concept of health education reflects a discourse grounded in the traditional educational model, defined as the act of enabling the provision of information to the public and other professionals. Those concepts arise from the knowledge linked to traditional academic training, which emphasizes the transmission of knowledge.[10]

The educator Paulo Freire refers to that type of education, when stating that education is not transferring knowledge, but creating possibilities for its own production or construction. Those involved in the educational process should base on the testimony of life, and not on the mere transmission of knowledge, otherwise, there is no learning. The autonomy, dignity and identity of the student must be respected; otherwise, the school becomes empty and meaningless.[11]

The vision of traditional education, although hegemonic, is not the only one among the participants of this study. Some deponents conceive health education as a dialogic practice, mediated by the exchange of knowledge between the actors involved in the educational process. In this sense, education should empower the user/family/community in order to enable the construction of knowledge grounded in popular knowledge, in the student's world, a vision strongly influenced by the liberating education of Paulo Freire.[11]

Such conception of education considers being possible and necessary the shared construction of common sense knowledge -

knowledge that emerges and is sustained in everyday social subjects - and scientific knowledge - knowledge produced by the scientific method. The construction of knowledge takes place, therefore, in a continuous interaction process, in which the subjects endowed with different knowledge related through common interests.[12]

A study in Juiz de Fora, Minas Gerais, with nurses from the FHS, also demonstrated that shared and dialogical way of conceiving education. Some of the interviewees perceived the health education actions as an opportunity to develop people's awareness of the importance of co-responsibility, towards an empowerment process that anchors the concept of health promotion in contemporary times.[13]

In this sense, health education requires an emancipatory practice, in which the user must be understood as the subject of his/her own history, free to exercise his/her autonomy and to decide on his/her health.

Thus, educational activities take over a new character, more adherent to the principles proposed by the FHS, especially the right to health as a guiding principle and the user's choice capacity as an indispensable condition. Therefore, it is essential that the health sector bases the groups not only on transmission of historically accumulated knowledge, but also, mainly, on the perspective of the construction of knowledge by those who integrate it.[14]

It is important to mention that, beyond the conceptions of health education, respondents also spoke about their experiences as educators. In this sense, the activity of health education bases on the way the nurse's self-perception in that practice, as a subject who performs it in his/her professional routine.

When asked about health education, nurses reported performing them in the activities carried out in the PHS, such as in education groups - to pregnant women with hypertension or diabetes - nursing consultations, waiting rooms, in school education, among others.

The educational groups performed by nurses are predominantly linked to programs and policies of the Ministry of Health, that is, aimed at required actions already established in the context of family health.[1]

This is perceived as a counterpoint to the magnified view of educational action, understood as one that should not only occur in vertically recommended themes, but also guided by the needs of individuals and communities, taking into account the local situation and the people involved in making education.[12]

Moreover, it is evident that the conception of group mode of health education, evidenced significantly in the nurses' speeches, also presents as the most commonly held practice, clarified in the participants' report.

Therefore, when approaching the conceptions and the nurse's practices regarding health education, it is notorious that the meaning given by that professional to educational practice reflects his/her own educator posture, given that his/her practices have direct relationship with his/her representations of education.[15]

Respondents could, besides reporting their practices, realize and reflect the conditions presented as facilitating and hindering to its realization.

The nurses pointed, in an emphasized way, how the motivation of the team, people's adherence, the appropriate infrastructure (human, physical, and material) and the participation of graduation students are essential for the development of educational activities. Furthermore, they stressed the bargain as a strategy they use and that they perceive as positive for the realization of health education.

About this aspect, there are points to be considered. Some types of resources that professionals use to encourage the user to participation in health education activities are harmful. One cannot forget that resources like bargain and coercion bind participation.[16]

The use of those resources strengthens practices such as client relationship and welfare assistance and, when they cease to exist, users no longer participate. Thus, the educational process should be conscious, free and spontaneous, by people's choice, by the option of experiencing the educational action, and not encouraged by any bargain mechanism.[16]

Regarding other aspects considered facilitators, it is undeniable that the presence of a cohesive team presents as a motivating factor for nurses, which leads them to realize such an element as an educational practice potential.

For the development of educational activity to occur in an expanded and qualified manner, all members of the multidisciplinary team must perform it, each one based on the corpus of knowledge, making important contributions, adding value to this practice.[17]

In this context, there are the graduate students who, although not being part of the health team, become part of the working

process when performing the supervised training and the practical lessons of the undergraduate courses, which also configure as a facilitator for the nurses of this research.

Such evidence is commonly observed in scenarios that receive undergraduate students, which reinforce the contingent of human resources for the team and allow it to expand its range of actions.

There is a counterpoint worth mentioning in this context, since one observes, often, that the graduate student becomes the mediator and coordinator of educational activities in the communities, without the staff involvement. Therefore, the participation of professionals is also essential to ensure the continuity of educational processes.[18]

Furthermore, the provision of material resources and an adequate physical structure appear as elements that enable the best educational practices in the health services routine.

As for hindering aspects, it is noteworthy the population's non-adherence and the lack of human, material and physical resources. In this context, there is the overload of management and care activities that are commonly in charge of nurses in the FHS, hampering the time availability to devote to educational activities.

The literature suggests that the population's poor adherence to educational activities is, in fact, something that occurs in the practice of FHS. That reality bases greatly on the nurses' little knowledge on the dynamics of families and communities, in addition to their own resistance to change the care model, by both professionals as users. Hegemonic transmission of knowledge ends up generating an understanding information restricted to users, making the educational activity meaningless.[13,17]

For appreciation and acceptance of the educational work by users and team members, everyone needs to clearly understand the objectives of the FHS, and work together towards the consolidation of the current health care model.[17]

Regarding other complications reported by nurses, they corroborate the ones described in the literature. The lack of financial investment in equipment and physical structure of the Health Unit, added to the high demand of service and high bureaucratic activity in the FHS are listed as difficulties in carrying out health education practices in the context of family health.[13]

Study brought to light that professionals report many difficulties of management nature. That reflects in a number of barriers related to work process, culminating in a great service demand and, often, lack of technical resources to optimize communication between the FHS and users, such as educational materials and audiovisual resources.[16]

With regard to material resources, it is unquestionable they provide support in the process of health education and have an important role in mediation of professionals and users.[4] However, the lack of material resources does not justify failure to undertake educational activities, since human resources superpose material, becoming essential for such activities to occur.[16]

It is evident that the enabling and hindering elements listed by the surveyed nurses anchor in group mode of health education. It reveals they commonly ignore or leave to second plan the possibility of educating through the extra-group activities involved in their professional routine (eg: nursing consultation, home visiting, receptiveness), whose requirements do not focus on the additional supply of physical, human and material resources, but on the self-education posture.

The literature corroborates that issue by pointing out that the educational component present in nurses' praxis develops in four different environments: the school, the workplace, the clinical environment at different levels of performance, and the community. Thus, the educational act permeates the entire professional practice and different scenarios, and must be optimized with the use of various resources available to the professional[19].

Although not representing the report of the nurses group, one aspect mentioned as a problem was highlighted in this research. It is the view of one of the nurses, who reinforces the low levels of education and enlightenment of the population as complicating factors to understand the education conducted by a health professional.

Such speech suggests that it is up to the user/family/community to understand the technical language of the health professional, when, in fact, the professional is the one responsible to approach the common sense world for, from this reality, mediating the process of knowledge construction. Another study[19] confirms that issue, in which the educational action should be structured in order to research and meet the population's needs, and use communication mechanisms to

facilitate understanding and encourage their practice. The low educational level should not, therefore, be a hindrance or seen as a problem of the educational process.

Educational practices maintain the approach that does not incorporate the understanding of the needs, demands and knowledge of the population, an element that calls into question the constructive potential of health education.[12] One should not ignore that the user carries a knowledge diverse from technical knowledge, but that should be valued, in order to, subsidized in his/her own world view, find strategies to promote, maintain and restore his/her health.[20]

The results of this study have identified how nurses designs and builds health education of the FHS routine. Evidence suggests that such practice is still very significantly linked to the group-work mode and the traditional methodology, based on the transmission of professional knowledge for users.

With regard to the practice of health education itself, it is clear that nurses refer recognizing it in daily activities performed in the FHS routine - especially those that occur in group mode and recommended by the Ministry of Health. That context show various elements that limit and/or potentiate the health education in their professional practices.

The findings of this research reflect the views and practices of health education of certain reality with a specific group of professionals, which configures as a limitation of the study. It implies the impossibility of generalizing the results, despite such results corroborating the relevant literature on the theme.

CONCLUSION

It was evident that the professionals have designed health education activities significantly in-group mode, based on a transmitted/banking methodology. Such views reflect directly in practice, especially when involving aspects that facilitate and hinder health education in daily work. In this context, they stressed that there is a strong connection among educational action, group mode and the verticality of the programs recommended by the Ministry of Health.

The intrinsic motivation of education, considered the driving force for such action to happen, was sidelined in their speeches, hitching health education to extrinsic factors such as bargain, material resources, physical infrastructure, among others.

Those findings indicate that the nurse's concepts and practices of health education show that the representation of educator still appears far from their professional identity as it anchors in specific modalities and external elements so that they can be effective in everyday health services.

This research signaled important elements that deserve to be reflected and reviewed in the framework of the nurse's education and practice, culminating in new meanings and new practices in health education so that they are created, in fact, as tools for reorienting care model proposed by the FHS.

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