

Health Education: Curiosity as a Parameter of the Freirian Model in Primary Care*

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Abstract

Introduction: The educative actions in health promotion are intended to develop, in individuals, family and communities, the capacity for perception of their health needs and joint participation in their resolution, bearing in mind their possibilities. Education on the effectiveness of health promotion practices is an effective instrument, which has been implemented through different methodologies. The traditional health education model based on Paulo Freire's philosophy is widely used in the Brazil Unified Health System.

Objective: Identify curiosity as a Freirian parameter of health education in primary care.

Methods: This is a descriptive qualitative study carried out in the municipality of Juazeiro do Norte, Ceará, Brazil. In all, 31 nurses from basic health units (UBS) and 12 users from the Unified Health System participated in a semi-structured and observational interview mediated by context interpretation in individuals who participated in educational groups. The organisation of the material collected for the search took place on the basis of Bardin's proposal and the analysis was based on the epistemological characteristics of Paulo Freire.

Results: Traditional pedagogies were used during the development of the interviews. It was observed that the educational activities which focus on disease are still an obstacle to promoting a critical awareness of users. Once the nurses were limited to this methodology and the users complied with the guidelines, favouring their naive curiosity, they followed the prescribed instructions mechanically and without understanding, possibly involving temporary behaviour changes. The

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curativist/biomedical model was used during these activities. Curiosity was expressed via clarifications and questions that arose during the health education activities. However, these clarifications were limited to the questions and answers that the users and professionals exchanged, which allowed for the transfer of information but did not stimulate the users to be reflective.

Conclusion: Curiosity, described by Paulo Freire as the learning process designed to produce active, critical, and reflective individuals, still does not happen in primary healthcare.

Keywords

Primary Healthcare; Nursing;
Health Education.

Introduction

Health education is one of the mechanisms of health promotion that assists in the training of the individual and the community to be responsible and involved with and able to identify, perform and satisfy needs by adapting to the environment in which they live [1]. This can be considered as a knowledge-building space, where it is necessary that individuals have an active posture and reflective criticism, leading to autonomy. Health promotion is a challenge in the health–disease process because its scope is greater than the specific field of health and involves other health determinants [1-3].

Health education is done mainly in the primary care setting, where it forms the base and determines the work of all other levels of assistance in order to coordinate, rationalise and direct the use of resources, basic or specialised, for promoting, protecting and improving health through multidisciplinary work [2]. The incorporation of health education into the practices of basic health units (BHU/UBS) through multidisciplinary orientation groups implies territorial recognition and identification of requirements, in addition to providing a good climate for information exchange [3]. However, a study of the process of professionals' work with regard to health education is still behind the effective practices, not only relative to views of

user empowerment, but also due to limits in the transmission of information, clarification and learning [4].

Health education groups are characterised as a process mediated by the professional (informs) and user (receives the information), where dominated by the idea that educating has knowledge and learn who does not know anything. Along with the need for an attitude change, a transformation of the work process is perceived, including the user as an active subject of this process [4].

In this context, Paulo Freire's pedagogical approach recommends a dialogue between educators and students regarding the construction of knowledge in which both has the opportunity to research and study; this action is pervaded by concepts such as reading the world, questioning and curiosity [5]. Thus, the knowledge is built collectively and is mediated through dialogue and articulated with territorial experience. This is an integrative and interactive practice in health educational groups [5]. Still, the exercise of curiosity must be present so that individuals can unveil the reality and stimulate learning since curiosity is an engine for knowledge [5-7].

Assuming the change of life habits and healthy practices, curiosity is an important factor in the process of educational groups. Thus, the objective of

this study is to identify curiosity as a Freirian construct model of health education.

Methods

This is a qualitative descriptive study, conducted in the municipality of Juazeiro do Norte, Ceará, Brazil, in the period September 2013 to July 2014. Two groups were selected: nurses and users of the BHU. The inclusion criteria were: nurses assigned to the health units for at least the previous six months and their established presence during the collection period. The individuals considered to be users must have participated in the educational activities carried out by nurses for at least six months.

- The municipality consists of six Health Districts, totalling 66 family health teams. The nurses were selected by contacting the city's Secretariat of Health. Out of the 66 units, 45 remained once each unit was assessed for the pre-established inclusion criteria.
- Out of the 45 nurses initially selected, five refused to participate in the research and according to the saturation criteria adopted, the recruitment ended with 31 nurses. A total of 12 users were identified.

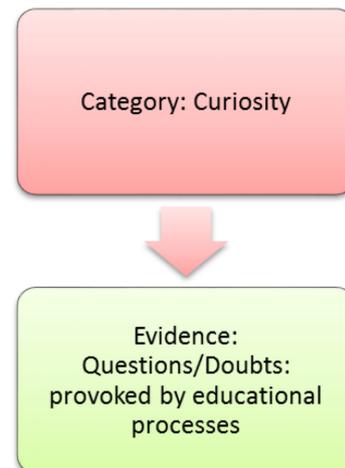
For data collection, a semi-structured interview and observation mediated by a checklist were used in order to study an approximation of reality. The *checklist* used here was found in Machado's [8] study, with a view of a harmonisation of educational activities developed by professionals using the family health strategy. The interview process was conducted to get to the end of the data collection. Therefore, the saturation was determined when the testimony focused on *questions* and *clarifications*.

Bardin's [9] content analysis technique was used, following the organisation of data in stages. The *corpus* of this research consisted of 31 interviews conducted with nurses and 12 held with users, in

Figure 1: Registration units, units of context and analytical categories according to the Bardin technique. Juazeiro do Norte, 2014.



Figure 2 Description of the categories and evidence from the study. Juazeiro do Norte, 2014.



addition to the material obtained from four empirical observations applied during the educational groups.

After the construction of the *corpus*, the *records units* and, later, *the context units* were identified and coded. These were found in the conversations, through words, which were grouped according to their similarities and meanings. Then, the *context units* that provide interpretation for the analysis were built. After identification of these units, the material was organised according to the analytical category, with reference to the theoretical framework of educator Paulo Freire – “epistemological categories” found in his legacy and compiled by Sfredo and Ecco [6]. Thus, as shown below in **Figures 1** and **2**,

in the registry unit, context unit and study evidence were identified in the analytical category.

Figure 2 presents the category and evidence that guided the process of organisation of this phase of the study.

The design of this study was referred to the Committee of Ethics in search of ABC Medical School, and was approved under number 195,428, on 2 February 2013, fulfilling the formal requirements laid out in Resolution 466/12.

Results

In all, 31 nurses took part in this study, with 30 being female and one being male. The nurses were between the ages of 24 to 55 years, had between 2 and 22 years of training and served in the health unit for between six months and 12 years. In relation to training, the nurses had expertise in the area of public health and/or family health. In relation to the users, 12 users were interviewed, with 10 being female and 2 male. The users were between the ages of 18 and 75 years and were participants of educational activities developed by the nurses.

With reference to the categories of the study, to get the evidence expressed in the conversations, as well as records of the moments of observations. The educational activities that focused on disease were still found to be an obstacle to promoting a critical awareness of users, since the nurses are limited to the responsibility of transferring information; it is up to users to obey the guidance function, favouring so, a naïve curiosity, that is, geared to perform the

prescribed instructions upon information passed on, which may involve temporary behaviour changes (**Figure 3**).

Questions and clarifications

The curiosity of users

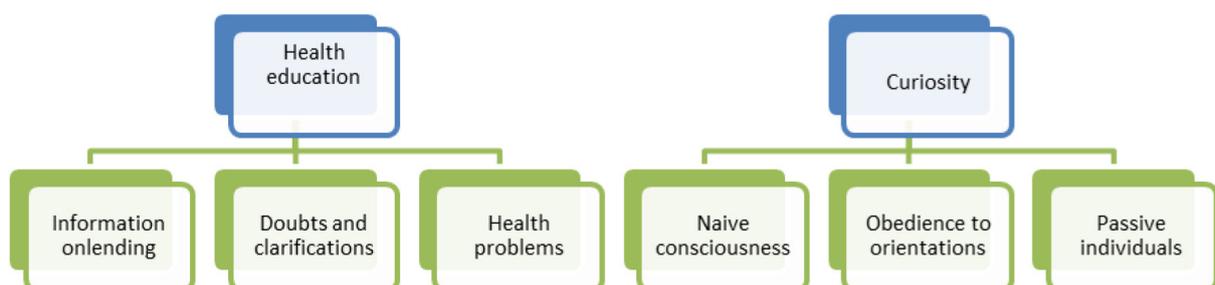
Discussion

Two educational models were applied to the health education activities. The first model is the traditional model of health education that is centred on the transmission of knowledge and experience of the educator, giving importance to the content taught in the context of reproducing that information. In the second model – the dialogic model – health education is a process of change and transformation characterised by an individual emancipatory philosophy.

In the identification of curiosity as a Freirian construct model of health education, the process of health education (based on the dialogic perspective) is characterised by involving the educator and learner in moments of exposure or talks about the object, with moments in which those involved maintain an open, curious, and questioning environment, with an active posture while they speak or listen [5-7].

This presents itself as a field of interdisciplinary theory and practice, committed to the implementation and evaluation of educational processes aimed at the promotion of autonomy, participation and ethical behaviour, in addition to the co-responsibility and safety of individuals and communities with re-

Figure 3: Curiosity evidenced in the educational practice of nurses.



gards to their health issues and the environment [10]. In this context, with regard to the attitude of the users towards the educational activities developed by the nurses, it was evidenced that participation in them was mediated by questions and clarification of doubts, as illustrated in the testimonials below.

Users actively participate in the guidance provided, seeking to clarify doubts regarding your complaint.

Nurse 2.

Most accept positively those moments [...] participate in and even asking, during the actions, many questions that they have with reference to their respective diseases.

Nurse 5.

Users have demonstrated good participation in educational activities, asking questions, attending and demonstrating comfort with the team

Nurse 7.

[...] users participate actively during the consultations, ask questions and clarify many doubts.

Nurse 12.

People can express their needs, their doubts, and the whole group interacts [...].

Nurse 35.

The above statements show that during the educational activities, the users were limited to clarification regarding the disease, revealing an education based on the transmission and reproduction of knowledge. Curiosity is driven by the desire to meet or unravel questions about the health problems and adaptation of a healthy lifestyle.

Health education is seen as an education system that includes principles and guidelines in a way of educating with approach of focusing on social issues. It is a way of being in the world that is based on social relationships, both at work and in

education [3, 10]. In a study carried out in South of Brazil, Brazil to identify the purpose of the communication process in group activities, the authors found that health education mostly is designed as a one-way transmission of content [11]. In order to understand the popular educational practices, Moura [12] also showed that the majority of user participation was due to the need to learn to adapt to a healthier lifestyle, stabilising pathologies, and promoting physical and mental well-being.

However, considering the Freirean way of thinking, curiosity takes place from the moment the individual, during a teaching–learning activity, moves from a naïve curiosity to a critical sense. Thus, the educational practice must stimulate curiosity and make it increasingly critical, providing knowledge-creating situations and making the educational act authentic [7, 13].

During the observation of the educational practices performed by nurses, it was realised that the practices were focused on preventing disease, and although they mediated dialogue, any curiosity manifested in discussions that focused on removing questions that arose related to the thematic material. This reality was also observed in the users' testimonials. It was clear that there was a desire to clarify health-related doubts and be obedient to given guidelines.

What I do is obey whatever he says there; follow what he guides.

Us 9.

[...] nurse taught to do so, I will do so.

Us 11.

[...] With him, teach what I couldn't and I do what he says.

Us 12.

Curiosity is revealed on the part of users while they ask questions; however, is quite incipient, since they only are obedient to the guidelines given.

In Silva et al.'s [14] study, users stated that during the educational activities, the health professionals educated about correct practices. During those times, there were some questions from the users and upon receiving answers, the users memorised them and were given practices to follow.

Self-centring practices, based on the dissemination of health information and treating the user as an object that is outside of the care process, have a temporary effect related to behaviour change [15]. The educational process, under this perspective, is a relationship between those wise men and those who think there is nothing to know. The contents transmitted are decontextualised reality cut-outs, preventing the learner from having the experience to perform, which is required for the development of critical awareness and autonomy in making choices [5-7, 13].

Among other concepts, health education requires a combination of opportunities that promote health maintenance and promotion. Thus, it is not understood as only transmission of content, but also as educational practices that seek to help the subject develop autonomy in his or her life; namely, health education is a full exercise of citizenship [10, 16].

The process of curiosity is inherent in every human being and the ability to be curious enables the unravelling of the world. In this way, being curious involves finding experiences that can satisfy that curiosity [5-7, 13]. In order to boost this curiosity, the educational practice should provide situations that create knowledge, making an authentic educational act, and at same time, developing critical learners. Curiosity motivates individuals to reveal reality through actions that stimulate learning and are an engine for knowledge [5, 7, 13].

Participatory educational strategies cannot be thought of without the establishment of a link between the action and the culture of the learner, the enhancement of knowledge intrinsic to it and that which is part of one's life context [17]. While the nurses in the study with preventive speeches still

focused on the adaptation of healthy lifestyles, if they provide discussions that only involve the transfer of information rather than the construction of knowledge, the criticality of the users is hindered, making passive people.

The integral attention implies new practices of care and management, in which health professionals and users assume co-responsibility in the construction of conditions that are favourable to the personal and collective health. Link relations and cooperation should be the basis of interaction for the common welfare, which requires communication processes based on respect, and commitment as well as on availability and mutual confidence, an attitude that should guide proposals for health education, both in health services and in the communities¹⁸. In this perspective, nurses need to have a critical activity and social practice that reflects a constant information-seeking position around their praxis [16].

When the health education does not lead to this reflection, it is, instead, a practice characterised by taking a naïve consciousness, and according to Freire [5, 7, 13], this offers features like simplicity, without a deeper understanding of the causality of the fact. It also means having satisfaction with the experiences, and having a fragile understanding of the problems without being able to clarify the issues, in addition to perceiving reality as static.

The critical consciousness, characterised by the deep yearning for an analysis of problems and an understanding that the reality is mutable, reaches authentic principles of causation, checking the findings and the reviews, analysing facts and seeking answers to questions. In addition, it brings concerns to light, searches for authentication, and repels all transfer of responsibility and authority, while accepting delegation and seeking inquiry, research and dialogue [5, 13].

It should be noted that in this educational process, both the nurse and users must have this critical conscience; the professional should be open

to questions and understand reality in terms of constant dynamism, and users should understand health education as a moment of exchange of experiences. This should make the educational experience a place for reflection.

For both, in this educational process, which involves learning, as the information is presented to the individual, a reworking, and even a deconstruction of knowledge, is needed, aiming at a new construction, based on reflection and criticality relative to a flow of information that is constantly updated [19].

In the context of primary healthcare, health education represents one of the tasks of the professionals working on health teams, highlighting the work of the nursing process, since the conceptual bases of nursing advocates for the role of the nurse as an educator [20].

It is important to reflect upon the elements that lead to this educational practice with preventive features, centred on stock requirements, resulting in curiosity on the part of users that is limited to questions about health problems. In this way, there should be training for nurses in the use of new methods of making health education stand out, as well as changes in the attitude of the users, which although sometimes can be a challenge in punctual or prompt practices, towards an attitude that is dialogical, open, and curious, rather than passive.

It is understood that the nurses, to conduct health education, whether individual or collective, should develop differentiated education, with strategies that facilitate learning and emphasise the needs of the population with effective and efficient actions [21]. However, this ministerial obligation often intimidates the professional to provide full assistance, making him or her act in compliance with the standards that focus on the cure and prevention of diseases, and do not necessarily meet the needs of the entire population [22]. This reveals the need to reshape healthcare and transform the process of work [23], starting with changing from a focus on

the disease and instead turning to the needs of the individual.

Thus, when inserted into the FHS, the training and qualification of professionals are revealed as essential in order to look for the gaps in knowledge and attitudes, giving a way for healthcare professionals to understand and meet the health needs of the population, as well as to facilitate the organisation of services and transformation of reality [24]. Health education represents an instrument of care that gives the accession to health practices, creates links and restructures the relationship with life [25]. Other authors confirm that health promotion in FHS implies a new look for the professionals that are part of the multidisciplinary team, taking on the perspective of an expanded concept of health and of completeness as a principle of action, using an inter-sectoral approach, with the articulation between theory and practice as guiding shafts. In this sense, the process of permanent education to fill the training gaps of professionals is essential [26].

Therefore, there needs to be an update to the type of education required to perform the work, as the knowledge is dynamic and every day, there is new information that the professional needs to seek and follow. As vocational training implies the process of developing work-related skills, it also serves to fill gaps in knowledge, promoting personal and professional growth [10, 16].

In this way, the nurse is responsible for the effective implementation of the health education programme, in the way they retain knowledge, seeking transformation, which meets the Freirian thoughts when it reveals that the change is not a unique work of some men, but rather, it is available to those who choose it and who are subject to the process of transformation [5, 7, 13].

The nurse must understand the common reason for participation as a basis for exercising citizenship, which is where the empowerment of the population is an essential element since the process of empowering the community seeks to strengthen

the construction of autonomy and citizenship in the control of conditions and determinants of health [27].

There is a path to be traversed to attain an effective health model accepted by the primary healthcare and health promotion practices; here is the importance of every team participating in the planning, implementation and evaluation of educational activities. The involvement of other sectors of society brings encouragement and guidance for health education and emancipatory dialogue becomes effective [27]. The intersectoral approach confirms an action on the individual conduct, where the subject who is passive and dominated gives space to the subject who is able to take care of himself or herself, revealing the freedom of action as being essential to this new specificity of BioPower [10, 13, 28].

It is important that educators understand the learner not as a taxable and uninterested person, but as active and committed; however, educators must promote learning that attracts the interest of students and arouses their motivation and memory [30, 7, 28].

The educational process is a political process whose methods and techniques should promote desalination, transformation and emancipation of the community involved. This cannot be exclusively informative because it is necessary to encourage users to reflect and realise it more not as a concession, but rather, as a social right [28-30]. It is necessary that health professionals listen and practice health education using a knowledge-building process. In this way, autonomy of the people under their care can be promoted, while at same time, empowering them [22, 30].

Within this perspective, it is evidenced that the practices of health education are characterised by the traditional model of health education, which corresponds to the form of education regarded by Freire [11] as bank education, in which the role of the educator is to "fill" the students of content, making deposits of communiques. In this vision,

humans are passive beings, so it is up to education to adapt them to to reality. Contrary to traditional education, the claim of education is to prepare individuals to reinvest acquisitions in a variety of contexts – in situations of everyday life [7,10,29,30].

In the dialogic model of education, problem solving implies the active participation and constant dialogue between students and teachers. Learning must be conceived as a natural response to the challenge of a situation/problem [10, 13, 28, 29, 30]. Thus, even if you have the knowledge that actions consistent with the assumptions of health promotion are of great importance to the quality of life and equity in health, implementing them is still a challenge, given the predominance of practices of traditional educational models. Therefore, naïve curiosity was expressed by clarifications and questions in interviews and was limited to questions and answers exchanged by professionals and users.

Health education models identified in the health system are traditional with incipient dialogue and are very limited in the construction of knowledge in terms of the transfer of information without stimulating learning and reflection on the priority of behaviour change. The educational actions in health promotion are intended to develop in individuals, families and the community the capacity for perception of their health needs, allowing them to jointly participate in the resolution in view of their possibilities. Health education is an effective instrument for the effectiveness of health promotion practices and can be implemented through different methods. The traditional health education model based on the "curiosity" parameter from Paulo Freire's philosophy is exercised in primary healthcare.

Traditional pedagogies were evidenced during development of the interviews. It was observed that the educational activities that focused on disease are still an obstacle to promoting a critical awareness of users, with nurses limited to this methodology and users limited to obeying the guidelines, favouring the naïve curiosity and performing the prescribed

instructions mechanically and without understanding. There is the occurrence of a curative/biomedical model during these activities. Curiosity, described by Paulo Freire as the modifier learning process in order to make active, critical and reflective individuals, still is not present in primary healthcare.

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