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Original Article

HEALTH EDUCATION AS PRACTICE OF NURSES IN FAMILY HEALTH STRATEGY *

EDUCAÇÃO EM SAÚDE COMO PRÁTICA DE ENFERMEIROS NA ESTRATÉGIA SAÚDE DA FAMÍLIA

EDUCACIÓN EN SALUD COMO PRÁCTICA DE ENFERMEROS EN LA ESTRATÉGIA SALUD FAMILIAR

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Descriptive, exploratory study, with a qualitative approach, which aimed at identifying knowledge and practice of health education of nurses from the Family Health Strategy, in November and December, 2009. The interviews, conducted with fifteen nurses in Crato, Ceará, Brazil, were subjected to content analysis. Four categories were identified: Conception on health education, Action planning, working in partnerships; limits and capability in implementing educational actions. The conceptions of health education still reflect a conservative view, but the practice was positive because it prioritizes several topics, using local resources and venues and involving other sectors. The difficulties were related to excessive assignments, interaction with certain groups and discontinuity of actions. There is the need for better coordination and organization of the health service in the pursuit of partnerships with emphasis on interdisciplinary and intersectoral activities aimed at health promotion.
Descriptors: Nursing; Health Education; Family Health Program; Health Promotion.

Estudo descritivo, exploratório, qualitativo, que objetivou identificar os saberes e práticas de educação em saúde de enfermeiros da Estratégia de Saúde da Família, entre novembro e dezembro de 2009. As entrevistas, realizadas com quinze enfermeiros em Crato, Ceará, Brasil, foram submetidas à análise de conteúdo. Identificaram-se quatro categorias: Concepção sobre educação em saúde; Planejamento das ações; Trabalho em parcerias; Limites e potencialidade na execução das ações educativas. As concepções de educação em saúde ainda refletem uma visão conservadora, mas a prática se mostrou positiva, pois prioriza diversos temas, utilizando recursos e espaços locais e envolvendo outros setores. As dificuldades foram relacionadas ao excesso de atribuições, a interação com determinados grupos e a descontinuidade das ações. Há necessidade de melhor articulação e organização do serviço de saúde na busca de parcerias com ênfase para interdisciplinaridade e intersetorialidade dirigidas a atividades de promoção da saúde.
Descritores: Enfermagem; Educação em Saúde; Programa Saúde da Família; Promoção da Saúde.

Estudio descriptivo, exploratorio, cualitativo, con objetivo de identificar los saberes e las prácticas educativas de enfermeros en la Estrategia Salud Familiar entre noviembre y diciembre de 2009. Las entrevistas, realizadas con quince enfermeras en Crato, Ceará, Brasil, fueron sometidas a análisis de contenido, identificándose cuatro categorías: Concepción de la educación en salud; Planificación de educación para la salud; Trabajo en sociedad; Límites y potencialidad en la ejecución de las acciones educativas. Las concepciones de educación en la salud aún refleja una visión conservadora, sin embargo, en la práctica educativa se buscó articular diferentes temas, utilizándose los recursos y espacios de la localidad e involucrándose diferentes sectores. Fueron dificultades de las actividades de promoción: sobrecarga de trabajo asistencial, interacción con ciertos grupos y discontinuidad de las acciones. Es necesario mejorar la coordinación y organización del servicio de salud, buscando alianzas, principalmente, interdisciplinares e intersectoriales dirigidas a promover la salud.
Descriptores: Enfermería; Educación en Salud; Programa de Salud Familiar; Promoción de la Salud.

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INTRODUCTION

In order to answer the growing expectation for a redirecting of public health, the 1st International Conference on the Health Promotion, in 1986, in Ottawa, Canada, which is defined as the process of training of the subject to act in the improvement of the quality of life[1]. From its initial statement, the concept of promotion of health was enhanced and it became a way to see health and the disease, dependent on intersectoral actions to reduce social imbalance and iniquities in health[2].

Along this direction, among the macro-priorities of the Pact for the Defense of Life, the relevance of education in health as strategy of promotion of health is outstanding. It is a resource that offers subsidies for the adoption of new habits and behaviors in health[3].

Considering the education in health a practice to be developed in several levels of assistance, an important resource under the perspective of the Family Health Strategy (FHS), is shown, once its comprehends the attribution of all the professionals who form this team. Studies confirm that among the members of the team, the nurse has developed actions of education in health turned to the subject, the family and the community based in the concept of promotion of health[4-6].

Under this perspective, the incorporation of the education in health to the practices of FHS, as a process of work, represent the effort of the health team to recognize the reality of the population, provide the due attention to their social needs in health, in their area of scope, besides being aware of the discussion between team members and the management. This social practice of construction of knowledge in health can contribute for the autonomy of the people under their care, once it establishes exchange of knowledge and is configurated as an act of creation and transformation of the reality which is an important reference to enable changes in the conditions of life and health[7].

So, it becomes vital to wake up to a new practice in the proposal of the promotion of health, for such, it is fundamental that the health sector, especially their nursing professionals in FHS, to lay the foundation of education in the transmission of knowledge, but they must emphasize the perspective of the construction of knowledge and the quality of life to all of those who are part of it[5].

It is outstanding that the conceptions of education in health which guide the practices of health have evoluted from the knowledge incorporated by the health professionals. So, two lines of thinking point to the concept of education in health, as follows: the Hegemonic Model, which has as focus the control of the process health-disease, performed to the transference of knowledge in health to the community, whose behavioral changes are normative and prescriptive. Differently from that one, there is Dialogical Model, in which the practices of health follow a more dialogical and emancipatory approach[8]. In this perception, besides the disease, other dimensions of life of the subject and his social context, and the 'social emancipation occurs and is inherent to the process of improvement of quality of life through the promotion of individual and collective health[5:322].

As exposed above, this article aimed at identifying the knowledge and practices of education in health of the nurses of the Family Health Strategy, in November and December, 2009.

METHOD

It is a descriptive-exploratory study with qualitative approach, made in the county of Crato, which belongs to the urban area of Cariri, in the state of Ceará, Brazil. The setting was the Basic Health Units with FHS. In the period of data collection, in the months of November and December, 2009, the county had 27 FHS

teams, from which 17 were placed in urban areas and 10 in the rural areas.

The research was made with the nurses of the FHS teams, who complied with the following criteria of inclusion: to work in FHS of the urban area, due to easy access. To be in this activity for at least six months. Two health professionals who were on vacation at the time of the research were left out.

The data collection was made through semi-structured interview with the nursing professionals, after previous scheduling. They were recorded, completely transcript and the data were submitted to the Analysis of Content. This technique occurs in the explanation and systematization of the contents of the messages and their expression, in which the data are arranged according to three stages: the pre-analysis; the exploration of the contents; and the treatment of the results, the inference and interpretation[9].

After the transcription of the interviews, exhaustive reading took place, the similar codes identified which were grouped into four categories: Conception on education in health; Planning of the actions; Work in partnerships; Limits and potentialities in the execution of the education actions and 14 sub-categories. Afterwards, the analysis of the data according to the consulted literature was made.

The participants were identified by letter N, corresponding to the word nurse, followed by the number of order of the interview (e.g. N1, N2...). The research respected the Resolution 196/96 of National Counsel of Health which establishes the rules on the investigation involving Aliens and received favorable legal opinion from the Committee of Ethics in Research of the Faculdade de Medicina de Juazeiro do Norte (FMJ) under number 2009_0236 FR 24713.

RESULTS

Characterization of the participants

15 nurses of the FHS were interviewed, most of them belonged to thefemale sex (14), aged between 24 and 47 years (average of 32.6 years), with time of completion of the graduation course from to three a 24 years (average of 10.2 years). Among the 14 specialized nurses, 10 were specialists in family health, all of them in the area of collective health. Regarding the time of working in the FHS, it varied between 1.9 and 8 years, with an average of 2.6 years. Thirteen nurses had specific training for education in health, some of the programs which form the FHS and two had no type of training.

In the analysis of the results of the interviews, when showing the images, feelings and meanings of the interviewed subjects, common aspects emerged which favored the elaboration of four symbolic categories and 14 sub-categories, according to what was shown in Chart 1.

Chart 1 - Distribution of empiric categories and subcategories of the knowledge and practices of education in health of nurses in the Family Health Strategies. Crato, Ceará, Brazil, 2009

Categories	Subcategories
Conception on health education	Prevention; Orientation for changes of behavior; Training of the community.
Planning of actions of education in health	Prioritization of the topics; Groups and topics; Resources used; Venues for educational actions; Results of the educational actions.
Working in partnerships to promote education in health	Participation of the community; Participation of other social sectors;
Limits and potentialities in the execution of educative actions	Interaction of the health team; Excessive attributions to the nurses; Difficulty of interaction with certain groups; Discontinuity of the actions.

DISCUSSION

Conceptions on education in health

Under this category, the participants expose their conceptions regarding education in health. It was made up by three subcategories: preventions, orientation for changes of behavior and training on the community.

Regarding the understanding on the education in health focusing prevention, the nurse reported on the factors of risk, the preventive actions before the breakout of the disease, when considering that *education in health is to show the factors of risk and to be able to prevent such factors* (N4). *I develop, because I believe that promotion will only occur from the moment we manage to educate the population towards prevention, so that they are not attacked by the disease* (N12).

Such conceptions were also evident in other states, in which the nurses of basic attention relate education in health to the process of promotion and prevention diseases, besides referring to the biomedical model in which the vision of health is routed to the absence of disease[10-11].

In the subcategory orientation for changes of behavior, another conception for education in health was revealed, in which the emphasis is on the change of behavior, founded in orientation and transmission of information, but they also lead to the awareness of self care. According to their justifications: *I believe that all and any action we take which wakes up the awareness of self care in the subject, then it is the knowledge he acquires* (N9). *Promoting health is everything you explain to provide orientation; we have to try to make changes of behavior* (N6).

In the nurses' statements, the concept strengthens the hegemonic model when it emphasizes the transmission of knowledge, in which the health professional keeps the knowledge[12] and ends up, afterwards, making the subjects responsible for the health-disease process, from the presupposition that they were brought up to prevent themselves from diseases. However, the education in health must be a process able to develop the critical consciousness of the real causes of their problems, and at the same time, to be ready to act for changes[13].

So, it is necessary for the nurses to widen their comprehension on education in health, and use strategies facing the development of a critical view in the subject, so that these subjects can be participants in the process of changing, so that these changes can be significative in their day by day lives.

In the subcategory training of the community, the participants used a speech which was adequate to the contemporary concept of the promotion of health, which means training of the community to work in the improvement of their quality of life, from the education in health. In this aspect, the social conditioning and determinants were outstanding, as well as the need to insert the population in a more active participation, according to the statements as follows:…*these are the exchange of information and the empowerment of population on health* (N5)…*it does not only involve us, to know and to pass on to other people the way to prevent disease, but it reaches the whole, basic sewage system, quality of life, everything, family welfare and income. It is a kind of social addition until you reach health* (N10).

It is noticed that there is comprehension of the need of training and autonomy of the subject and the community by part of the nurses, but this can be limited or enhanced from the established educational practices and the model of education in health used. It is recognized that this model is an important facilitating tool for the education of the community and a favorable element to the actions for the promotion of health. Therefore, the need to establish a dialogical relationship, one which allows interaction and reconstruction of knowledge and daily practices, has been registered[11].

There is the need for better education of the health professionals in order to value the educational practices and participation of the communitarian training in the process of work in health[14]. So, the nurse must comprehend the popular participation as fundamental to exercise citizenship, which has, as essential element, the empowerment of the population, once the process of qualifying training of the community aims at strengthening the construction of the autonomy and

citizenship in the control of conditioning and determinant factors of health

Planning of actions of education in health

This category groups five subcategories which describe how the nurses perform their work of education in health, from the choice of the topics to the assisted groups, the venues where they happen, even the results of those actions.

In the subcategory prioritization of the topics, the nurses revealed the criteria used to select the topics approached in the activities of education in health. These are prioritized, taking into consideration the epidemiological indicators, the situational diagnosis, the suggestions of the agents of health, the demand of the service or the free choice of the users. They are aspects of relevance once they aim at offering educational practices suitable with the real needs of the community added. *Through the indicators of the area we can observe a larger number of pregnancies in the adolescence* (N1). *Through the demand and the situational diagnosis of the area we can see the main attacks of disease in the area* (N7). *The topics are according to the need which is noticed in the appointments and according to the need that the community itself comes to us for help* (N11). *Together with the agents of health we see the need. They suggest the topic* (N13).

In a revision of the literature, it was identified that the educational activities were scheduled according to the availability of the community. The authors noticed that the educational activities had a higher impact and participation when performed from the strategies corresponding to the demands and the specific interests of the local culture[15]. So, it is noticed throughout the interviews that the nurses perform their educational practices according to the local needs and consequent demand of the community, keeping a correlation with what is established in the literature. Therefore, there is the possibility that the actions of those professionals can favor the improvement of the indicators of health.

The subcategory groups and topic establishes that the actions of education in health were directed to adolescents, elderly and pregnant women, the professional sex workers were also included. Among the topics most frequently approached were: STD/Aids, pregnancy during adolescence, hypertension, diabetes and pre-natal attendance. Furthermore, other subjects, such as human rights, sex, reproduction and citizenship were approached in the local contexts: *We work with adolescents explaining about SDT/Aids, ways of prevention, pregnancy in the adolescence and its consequences* (N14). *With the elderly I work with hypertension, diabetes and care* (N3). *I have monthly groups of pregnant women with lectures on pre-natal care*, on children and on women (N10). *The ones who reveal their condition of professional sex workers, we work on their sensibility to come to the health post. We worked for four months regarding topics such as human rights, sexual rights and reproduction* (N2). *This year we have already worked with the woman´s rights: rights at work, right to health, to have medical assistance, to vote, to be a candidate for a political post, focusing on her capacity to be acting* (N8).

Some of the findings show that the topics which were more developed in educational practices were defined from the groups that are assisted by FHS. So, the choice of the topic resulted from the careful listening to the demands. So, in primary attention, the works with the directed groups have represented an alternative for the assistantial practices, once it favors the highest participation of all and could become a link among them. To follow such conformation requires a higher involvement of the health professionals and the use of references, knowledge, ability of planning and attitudes with groups of primary attention in health[16].

In this study, it is observed that the nurses have directed their educational actions involving groups made by professionals of sex, besides the most commonly treated groups in the FHS, such as groups of pregnant women, hypertensive and diabetic. So, in a wider perspective it is also worth highlighting that they develop topics regarding citizenship with groups formed by the professional sex workers.

The nurses revealed that the resources used are the most participative for education in health. They provide education in health through lectures, workshops,

chat groups and individual approach. They used audiovisual and demonstrative resources to enrich them. The chat groups, also mentioned by some, value the experiences of the users. *We work in a workshop and the construction of knowledge, we distributed Kraft paper and they write what they know about the topic. At the end I make a theoretical exposition* (N4). *There are more lectures, but also workshops* (N7). *First we have a chat group so that they can know each other and their deficiencies as well, I do some group dynamics, show a video, but this is built up in the group*(N11). I work in an individual way, *only in the office, after the doctor´s appointment, we provide orientation on the patient´s self care regarding the correct use of the medication* (N5).

The use of popular education in health breaks the verticality of the health professional-patient. When valuing the interpersonal exchanges counterpointing the usual passivity of the traditional educational practices, the patient becomes recognized as a detainer of the knowledge on the process health-disease-care and able to develop a critical analysis on the reality and the improvement of the strategies of fight and coping[12].

Under this perspective, the subcategory venues for educational actions refer to those used by the nurses to carry out educational activities. In the lack of a venue at the health post, the nurses use several available venues in the community, such as schools, churches and others. *At the health post we have a meeting room and then we finally got the chairs* (N9). *I give lectures at the school, at APAE...* (N6). *We don´t have a venue, we don´t have a room for education in health, that is important but it is not because there is no venue that we are not going to make the promotion of health* (E14).

The use of other venues to have educational activities is a way to optimize the communitarian areas and guarantee a higher participation and exchange of experience among the subjects involved. This has happened especially at schools with the participation of the nurses, which reinforces their role as educators of health[17].

In the subcategory results of educational actions the register on how the nurses perceive and value the educational practice was made, from the meanings and the answers given by the users during and after this moment of interaction, this reinforces the use of this practice according to the following statements: *I see that they end up absorbing. Sometimes we think that is nonsense to keep talking and they don't listen, but they end up paying attention, we noticed that it works* (N1). T*hey are more conscious, they have more knowledge and can opt by the use of the condom and take care of themselves, to have self care, I think that that is the most valuable thing there is* (N13).

These results were also common to a study which investigated the statement of the nurse on the educational practice at the FHS[13], in which it was identified that the education in health represents an instrument of care, which provides the adhesion of practices of health, formation of links and it is restructuring of the relation with life[18].

Working in partnerships to promote education in health

This category is on the intersectorality and search for partnerships. It is composed by two subcategories: participation of the community and of other social sectors.

The participation of the community in all process of education in health is referred by the nurses. The involvement of the community in the performance of educational actions, that is, promoting the venue, the tools or in the help of the formation of groups, potentiates the popular participation and it complies with one of the guidelines of the SUS (Unified Health System) according to these statements: *With the help of the community we work harder, the HCA (Health Communitarian Agent) brings the microphone, there is a boy who lends this sound box, a lady who has a little bar lends me the chairs and the tables* (N12). *To make partnerships is easy; I can bring the target public that I want to work with at that specific time* (N6).

It is known that the formation of the link with the community widens the efficiency of the actions of health and favors the participation of the user while rendering the service. So, the use the potential of the community represents an important strategy in the educational process[19].

The participation of other social sectors in the process of education in health is seen as the result of the efforts of the nurses who join the groups of youths, schools, universities, counsels, centers of reference of social assistance, besides other sectors. *Tomorrow we will be together at the Center of Reference of Social Assistance (CRAS) to analyze the strategies to do a workshop with the students of the school and the agents of endemic diseases* (N10). *You can involve other participants that the community can offer such as a group of youths* (N5). *I always invite other people from the counsel of the woman* (N8).

The Family Health Strategy is a facilitator of intersectoral actions, despites the difficulties and challenges to be conquered, but it is essential to build new knowledge to establish a new vision facing the problems and actions of promoting health[20].

In the present study, the intersectoral interaction as well as the interaction of mobilization of the community performed by the nurses is noticed as a response to education and the promotion of health and these are sustainable conditions for the practices to be developed with the community. This behavior intensifies the participation, stimulates the autonomy of the subjects facing the transformation of the reality, thus favoring the empowerment of the community.

Limits and potentialities in the execution of educational actions

In this category, the workability of the actions in education in health is pointed out, as well as the problems and challenges faced by the nurses. It was delineated for four categories, from four subcategories: Interaction of the health team, excessive attributions to the nurses, difficulty of interaction with certain groups, discontinuity of the actions.

The subcategory interaction of the health team only has the easiness in the educational activities, being described by its interaction among the members, especially by the involvement of the HCA (health communitarian agents) and nurse technicians in the daily work of the FHS; besides the support received by the Health Department which makes some resources available for the execution of this practices with the groups or the community. According to these statements: *Easiness only from the HCA, who are very interested when we are developing an action of education in health, they participate a lot* (N11). *We have the support of the Health Department regarding leaflets, teaching material, folders* (N1). *I have a good team, good health agents who really work with me* (N7).

The responsibility of the fulfillment of the educational practices in the services of health has as indispensible component the participation of all the members of FHS. This demands a great effort from the health professionals in the planning of the activities, so that they can be attractive and assist the needs of the users[19]. So, the nurse needs to be prepared from a critical reflection of the actions of education in health and pursue mechanisms to widen and strengthen the participation of other health professionals.

The excess of attributions of the nurse was also pointed out as an obstacle for the development of the educational actions, justified by the lack of time, excess of attributions or a divergence between the educational actions and the productivity: *Due to the great demand and because we are always in a different place* (N2). We have a lot of bureaucracy to follow, the nurse of a PSF is the head of the program, and she is the head of the unit, so it gets complicated *for us to have one more responsibility in the education of health* (N9). *I think the greatest difficulty is the integration of the team, because alone is difficult* (N10).

As to the limitations of these practices, they are related to the lack of planning, inadequate venue, educational material and insufficient training of the health professional, once the education for the promotion of health and citizenship requires local political support and commitment[20].

So, the acting of the professional in family health becomes fragmented due to the overload of activities, especially for the nurses. This corroborates for the health professionals to stop performing educational activities and act exclusively in a curative way. However,

it is worth highlighting that the education in health is an indispensible activity to FHS, and therefore, must be prioritized even if that implies in the reorganization of the activities among the members of the team.

In the subcategory difficulty of interaction with certain groups, the challenges to interact and guarantee the participation of some groups of society were identified, such as: stigmatized groups (homosexuals, professional sex workers and drug users). Other reasons were: resistance to educational activities by the community, non compatible schedules and the need to have attraction/incentive.

The effort of some nurses to include this groups, when performing the activities in others social venues, but also facing situations which arouse fear or lack of ability to conduct actions when they are assisting drug users, as follows: *the difficulties: people are still very resistant, you set the day, the venue, they don´t show up, that is, there is no involvement of the population. When they get to the venue they don´t want to wait, they want to have the appointment and go home* (N3). *Here there is drug dealing and the drug dealers might understand that I am trying to stop the use and jeopardize their traffic* (N7). *I had to adapt myself to their schedule (professional sex workers) so they come to the health post out of their working hours* (N5). *We say there is going to be a draw, otherwise they won't come, especially adolescents that is why I prefer to go to the school* (N13).

The available resources to attract the users to the activities of education in health reinforce patronage and assistentialism and are different of the current model of education in health which is based on the enabling participation characterized for being conscious and of free will. So, the choice to participate must be an option to experience the educational activity and not stimulated by any mechanic of bargaining[19]. Therefore, the health professional must have ability to stimulate the participation of vulnerable groups in educational activities due to the difficulties they present in the access to health care. It is also worth pointing out the need of the health professional to have support and security guaranteed by the state agencies, to work with topic which presents conflicting interests, for example, the use of illicit drugs.

The subcategory discontinuity of actions refers to the difficulties the nurses have to have continuity of the actions of education in health, such as: absence of organization, lack of support of the managers, operational difficulties for the execution of the action whether by lack of necessary resources (teaching material, chair, venue) or by the lack of incentive and training; besides the difficulty in counting with the participation of the multidisciplinary team in the performance of such activities, according to the statements as follows: *the difficulties: lack of support from the Health Department, sometimes you want to do something different, but you don't have support. There is a lack of teaching material, lack of chairs ...* (N6). *The greatest difficulty I think is the non integration of the team, because alone is very difficult* (N11). *I think it is difficult to have continuity of the groups and provide education in health.* (N8). *Because I had an education completely turned to hospital care, I have a lot of difficulty to provide education in health* (N12).

These are known as barriers of organization of processes of work, due to the great demand of the service and also by the absence of technical resources to improve the communication between FHS and the users, such as teaching material and audiovisual resources[21].

It is known that the consolidation of collective work, which aggregates the specificities of each member, still constitutes a big challenge. However, the health professionals must consider essential the co-responsibilities in the development of all the activities. It is worth pointing out the current demands of attention to health requires professional competence in order to perform the actions of promotion of health[22].

So, it is believed that there must be a planning of the activities of education in health which involves the participation of the local managers and of the FHS to re-direct the practice, in a way to promote the responsibility of all the health professionals implied in the context of the promotion to health.

FINAL CONSIDERATIONS

This study was based on the knowledge and practices of education in health elaborated by the nurses who work in the FHS. It was observed that these health professionals value the practices of education in health and incorporate them to their daily activities. Through this instrument of care they aimed at responding to the subjective needs of the groups and of the demand of the adjoined area, even facing the present limitations of the health team and the venue.

However, according to the statements, it was identified that in the vision of these health professionals, the comprehension of the education in health is based on the traditional model, once it is considered as a preventive measure, with prescriptive actions, on the transmission of knowledge and orientation towards behavior changes; which expresses the need to enhance the comprehension on education in health as a strategy which values the participation of the subject and that this process is significative to strengthen the construction of autonomy and citizenship.

The effort of the nurses, when prioritizing topics of interest of the FHS, of the demand of the service and of the free choice by the users, is remarkable. And they are also agreeing with the lines of care recommended in the Primary Attention to Health. It was also identified the valuing and the optimization of the public areas present in the local communities to perform their educational activities. However, the activities were developed, mainly through lectures, with little focus on the dynamics of workshops and chat groups.

The nurses of the FHS raised questions regarding the process of work, referent to the need of deeply involving the team of family health, the community and the county health domain, in the actions of education in health, so that these actions become interdisciplinary, participative and attend to the proposals of promotion of health.

The nurses aim at developing interdisciplinary and intersectoral actions. However, there is a way to be followed for the effectiveness of the model of health accepted by the Primary Attention to Health and in for the practices of promotion of health. Therefore, it is important that the whole team participates in the planning, execution and evaluation of the educational actions, as well as other sectors beyond the health. A greater incentive and directing is needed so that emancipatory and dialogical education in health can become effective.

The study pointed out operational obstacles in order to offer educative activities due to the excess of attributions, lack of interaction with some groups, lack of educative materials, discontinuity of the action and support from the managers. In this perspective, for the development of the educational activities in the daily work of the FHS, the permanent education of the health team and the reorganization of the processes of work regarding participation and responsibility of everyone involved become necessary.

COLLABORATIONS

Oliveira MB and Leite CEA contributed for the conception, reading, interpretation of data and final reading for the approval of the article and made field research. Cavalcante EGR, Oliveira DR and Machado MFAS contributed for the conception, analysis, interpretation of data, reading of the article and final approval of the version to be published.

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