

The Practice of Health Education with Caregivers: Reflections of their Theoretical-Practical Conceptions

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In the context of human illness, it is expressed understandings about health, disease and care; leading to the discussion of their theoretical conceptions and practical implications for the daily services. The importance of health-disease concepts and their care practices make it possible to discuss the managerial, technical and educational interventions on a reality [1].

The health-disease-care process is a historical concept, regardless of individual and collective experiences and experiences of care (and non-care) with the body and with the environments, spaces and contexts of human life; because it is historical, has the biological, psychological, social, anthropological dimensions inseparable (cultural, ethnic, gender, political and economic), managerial and epistemic (in the sense of disciplinary and professional) [2].

Starting from the discussion of the concept of health-illness-care, one realizes that one of the current approaches includes the perception of the subject as to its condition. Effective care requires a close look at the patient's real needs and respect for their opinions about illness, their perceptions and their culture [3].

In this sense, you always or do not have the need to command or process the acquisition of information for or dialogue between patient and health professional, or not or professional that should determine or contain information, because name all the teachers experience mesma form or illness process [4].

The care activity has evidenced the tendency of those involved to become ill, because it is seen as exhausting and stressful physically and psychologically, often because the caregiver does not have guarantees of the daily contribution in the community and the family itself so that care happens [5].

The act, caring, is common to all cultures, although its forms of expression may be the most varied. Health care, particularly that which is provided in the hospital environment, is still quite restricted only to the technical part, the know-how, often leaving aside, the relationship of subjectivity between the subjects (the patient and the caregiver) and their needs. The privilege of the knowledge of pathology, physiology, and technique persists, to the detriment of the value of the knowledge of the human being and of what surrounds him. There are specific content gaps on care, in the processes of formation of the health area. However, in the curricula, universities and technical courses of the health professions, thematic and discussions related to the humanization of care and the rights and education of the users of health services need to be highlighted, since they are themes related to the care process [6].

When professionals internalize and take on the expanded concept of health care in patients, the technical work opens space for the guidance and education of the family and/or caregiver, broadening the look for integral care and overcoming the fragmentation of care [7].

The health care provided in the various health scenarios enables nursing to effectively carry out health education actions. All the moments that comprise interaction with the users should be considered propitious to develop actions of education in health. And the nurses, characterized as social actors responsible for care in the health service, have a diverse field of health education practices [8].

The sharing of knowledge should be related to the concern that the team has to integrate, in a participative way, the family members who accompany the patients during hospitalization [9].

In the context of the importance of integral care the needs of patients/caregiver/family, health education operates multiple dimensions of care (political, philosophical, social, religious and cultural); practical and theoretical aspects of the individual, group, community and society [8]. Thus, the importance of understanding the theoretical-practical conceptions that permeate health education practices, essential for nurses' actions in actions in health services.

The aim of this article is to reflect the educational practice carried out by nursing with caregivers on the perspective of the theoretical-practical conceptions of health education.

It is a theoretical-reflexive study, based on the critical reading of the theoretical-practical conceptions of health education with caregivers. In order to carry out this reflection, we searched for scientific basis in books, dissertations, theses and periodicals, by searching the database Scientific Electronic Library Online (SCIELO), Biblioteca Virtual em Saúde (BVS) e Medical Literature Analysis and Retrieval System On-line (Medline/Pubmed). For that, the descriptors caregivers or companions of patients or health education associated to the word nursing were used, allowing to establish the reflections on the subject.

The beacons that compose this article revealed the different conceptions that emerged from the reflections of health education practices with caregivers: The historical context in the rescue of the practices of health education with caregivers and Caring for the caregiver: empowerment of nursing and education and health.

Reflecting on the historical context that permeates health education opens paths in the understanding of how, why and for what happens the practices of health education carried out by nursing.

The last topic that deals with care for the caregiver has brought reflections on the ability to care, consequences of caring for the other, as well as some health education actions will be presented with caregivers so that nursing knowledge can be expanded.

The referential that will support the following reflections is constituted by the educational supports that encompass theoretical-practical concepts of the Ottawa Charter, the liberating pedagogy of Paulo Freire, of empowerment and culture, understood as essential concepts for the nurse's role in health education in actions in health services [10].

Historical context in the rescue of health education practices with caregivers

To contextualize the practices of health education, it was tried to make explicit the understanding of History, scenarios and subjects of practices, specifically nursing and caregivers, as well as the plurality of relationships: subjective, interactive and contextual in health education practices with caregivers.

The operationalization of the Ottawa Charter (1986) in the perspective of self-government, self-management and self-care seem to predominate in the articulations between health education and health promotion [10], from two actions: Reinforcement of community action and Development of personal skills, associating the perspective of decision making to change the health and disease scenarios.

These actions were rescued at the Fourth International Conference on Health Promotion and the Declaration of Jakarta: held in Jakarta in 1997 and in the Caribbean Charter - I Conference on Health Promotion in the Caribbean: held in 1993 in Trinidad and Tobago [11].

In history, health actions have shifted from focusing on the environment to the person, on the body, as a solution to prevent diseases and receive health; from the individual to the collective, coexisting with the duality between the banking conception of education and the problematizing education; to the concern of establishing a bond with the community, stimulating the development of the exercise of the autonomy of the population in relation to their health, satisfying their needs, exercising consciously the popular participation and the social control of the public policies for the sector.

In the process of education in the area of health was developed hygienic pedagogy, actions were taken to distribute separate leaflets on the means of avoiding illnesses through persuasion; implementation of “mosquito killers”, home visits, interdicting buildings, removal of patients; compulsory vaccination campaigns, participation and mobilization of individuals as a way of modifying health behaviors; imposition of norms and behaviors considered adequate and expansion of individualized medical care. Community medicine is born to cover a hole in the care, being considered a medicine for marginalized, whether urban or rural; but in no time, however, was the idea of the right to health [12].

In this context, the population did not always pass passively to events, there was refusal of the population against vaccination, the most striking facts of this popular organization being the so-called great revolt, which occurred against the campaign of compulsory vaccination, in 1904, coordinated by the physician Oswaldo Cruz; results of the November 1974 elections, with the victory of the Brazilian movement on the right (MDB) – the only opposition party that was authorized to organize during the context of the military coup (1964); the principles of primary health care, based on the recommendations of the Alma-Ata Conference; followed by initiatives to search for technical solutions built on the basis of the dialogue between popular knowledge and scientific knowledge [13].

Dissociated from the previous context, new experiences in the field of health education are pointed out, based on Paulo Freire’s dialogical method, ultimately configuring popular health education [14,15].

Two interfaces of the education and health relationship are configured within the Brazilian health framework: traditional and popular health education. Traditional health education advocates the adoption of habits and persuasion of individuals, who must adopt healthy behaviors (stop smoking, accept vaccination, have hygienic practices, take preventive tests, etc.) through contact with mass communication vehicles such as TV, posters and newspapers, or even through access to information provided by the educator. In addition to advocating representation on health and healthy living as an individual choice [13].

Contrary to traditional education, popular health education puts itself in favor of autonomy, the participation of people and the interplay between knowledge and practices. The popular education in health seeks to work pedagogically the man and the groups in the capacity of critical analysis on the reality and improvement of the strategies of struggle and confrontation, through a non-conductive and non-prescriptive educational dialogue, accompanied by a movement for community strengthening [16].

Influenced by the historical conceptions of health education, actions are sometimes performed for patients and caregivers/family members in order to transmit norms, rules and conduct for the proper functioning of services and does not share the reality of the same and especially the needs of individuals, maintaining the cultural gap between health professionals and those who should be the true protagonists of educational health actions, users and their needs.

Health education practices may be merely informational devices about health, which have the purpose of changing people’s behavior, producing standards and reinforcing guilt. From this perspective, the problem of poor health is transferred to the other, the one who does

not care and acts differently from the prescriptions issued by the discourses on health education. From this perspective, health education practices can contribute to and reinforce the idea of new hygiene by means of convincing and seductive techniques [16].

Currently, proposals for health education have been based on concepts that proclaim the autonomy of the subject, his participation and agency as author of his own choices. Considering the human being as a historical subject with possibilities to intervene in reality, it is necessary to dialogue with other disciplines and the continuity of these discussions should permeate all trajectory of professional training of nurses so that the movement of dialogue, construction, deconstruction, denaturalization and problematization become the foundations for the practice of educational practices in health [17].

Reflecting critically on health education practices, often others are bombarded with information considered essential to their adequate stay in health services and care for the other, and, even, it is made clear their full responsibility to follow the prescriptions and their guilt in possible distortions of the expected.

There are few studies evaluating health education practices for caregivers, in a study about which interventions are effective in promoting health (physical and psychosocial) in caregivers of people with chronic conditions, the results provided evidence that interventions to improve caregiver competence using instrument measuring caregiver knowledge provides benefits to education and caregiver support programs; and active information interventions can be helpful in improving depression and care due to overload, but also notes that there are insufficient test data to gather conclusions about these results and further research is needed to prove these findings [16].

In a study on what information palliative care and nurses provide for family caregivers, three themes emerged: the caregiver needs to take time for himself and accept help from friends and family; teach the caregiver to maintain a high standard of care for the sick person (use of equipment such as syringes, mouth care, administration of medications, reduce shortness of breath, and control of pain, nausea, diarrhea, and constipation); and educate caregivers about the trajectory of the patient's illness and signs and symptoms of the dying process [18].

However, the care team may fail to recognize and draw from the knowledge of caregivers/family members when planning and implementing care for the person. In order to achieve an effective therapeutic relationship, the need to maintain a supportive relationship has been identified that allows patients/caregivers to express concerns and feel that they are being understood [17].

The basis for health education activity with caregivers requires knowledge of the specific needs of the patient, critically examining the physical, emotional, and social needs of these needs and providing education and support to minimize them [18].

Caring for the caregiver: the empowerment of nursing and education and health

The activities of nurses have diversified and expanded, becoming a complex process, being understood by caring, educating and managing. However, it has been observed that, in practice, some nurses see in a restricted way the care provided by caregivers. It is believed that caring, associated with educating, enables conversion and diversification of knowledge, where they can be constructed, deconstructed and adapted to the individual and collective needs of caregivers [18].

Caregivers are individuals who take responsibility for caring. They are fundamental in the care, they represent the link between the patient, the family and the health services [14]. In most cases, caregivers care more about their care than about caring for themselves, spending much of their time on this activity [19].

Although the caregiver takes care of the other. In this care, you end up neglecting yourself and consequently influencing the way the dependent person is cared for.

The health professional can act in the care of the caregiver and not only in the specific treatment of the patient [18].

The lack of information/guidelines regarding the patient's illness can generate insecurity and fears in the caregiver, generating damages to the care, besides more physical and emotional exhaustion, carries insecurities and fears from the ignorance about the disease and the confrontation of other associated problems, being able to feel unprepared in several aspects, mainly emotionally [19].

The nurse as a health educator contributes to individual and collective awareness, questioning responsibilities and rights to health, stimulating actions that comply with SUS principles, mainly accessibility, equity, universality and popular participation. In this context, one stands politically in favor of freedom and the ability to believe that the other has a knowing and doing that need to be considered. However, if transformations are to be, professional competence and generosity, since at times the subject needs help to overcome obstacles, work difficulties, disorders and crystallizations [11].

There is a need for collective construction of educational proposals to establish awareness and pacing wheels for activation in health education practices and social control. These health education proposals need shared constructions that include all levels of management. Observing that the nurse assumes a part of responsibility in the construction of educational processes, in which facilitating and mediating methodologies of learning are used that allow the creation, criticism and reflection of the practices, improving their educational interventions, using strategies that improve the quantity and quality of results in caregivers [19].

However, research results have shown that nurses have used little time in their daily activities with educational actions to the patient and family, and that this practice has followed a technical and prescriptive line in which technical and administrative activities are prioritized. Contrary to this perspective, the nurse should identify vulnerable caregivers to suffer a problem in their health, in order to reduce the chance of occurrence of acute or chronic pathologies [11]. This context is relevant for programs to support caregivers in the hospital, an environment that should provide caregivers with mechanisms to facilitate multiprofessional support.

The role of nursing interdisciplinarity in health education was considered not only as competence in several fields of knowledge, but also the congregation of knowledge that could contribute to the practice of health education. This is because health problems are complex, covering elements that go beyond knowing about being biological [11], broadening the knowledge for the integrality of the human being.

This is how health education, as a plurality of actions for the promotion of health, needs to use didactic strategies that transform individuals socially inserted in the world, increasing their capacity to understand the complexity of health determinants [18].

In Conclusion, it is necessary to understand that educational practices with caregivers, addressing individual and collective needs, require the perspective of considering the determinants of health education: letter from Ottawa, Paulo Freire's liberating pedagogy, empowerment and culture.

The context of problematization with the participants in the health-disease-care process is the construction and deconstruction of health practices, from the approach of hygienic pedagogy; from the individual to the collective, coexisting with the duality between the banking conception of education and the problematizing education.

In this course, it is highlighted as principles for the empowerment of nursing in health education practices with caregivers: Reinforcement of community action and Development of personal skills contained in the Ottawa Charter, and popular education in health as influences the actions with the caregivers in a perspective of bonding, developing the exercise of the autonomy of caregivers in relation to their health, satisfying their needs, consciously exercising popular participation and social control of public policies for education and health.

Bibliography

1. Ferreira Debora., *et al.* "A experiência do adoecer: uma discussão sobre saúde, doença e valores". *Revista Brasileira de Educação Médica* 38.2 (2014): 283-288.
2. Fernandes Carlos Roberto. "Contribuição histórica da Enfermagem na formação do conceito processo saúde-doença-cuidado". *Revista da Universidade Vale do Rio Verde* 11.1 (2013): 371-386.
3. Lins Rilávia Nayara Paiva., *et al.* "Percepção da Equipe de Enfermagem acerca da Humanização do Cuidado na UTI Neonatal". *Revista Brasileira de Ciências da Saúde* 17.3 (2013): 225-232.
4. Nascimento Maria., *et al.* "Cuidado, Doença e Saúde: Representações Sociais Entre Pessoas em Tratamento Dialítico". *Florianópolis* 27.1 (2018): e3290016.
5. Gratão Aline Cristina Martins., *et al.* "Sobrecarga e desconforto emocional em cuidadores de idosos". *Texto and Contexto Enfermagem* 21.2 (2012): 304.
6. Mafra Simone Caldas Tavares. "A tarefa do cuidar e as expectativas sociais diante de um envelhecimento demográfico: a importância de ressignificar o papel da família". *Revista Brasileira de Geriatria e Gerontologia* 14.2 (2011): 353-364.
7. Gomes Ilvana Lima Verde., *et al.* "Compreensão das mães sobre a produção do cuidado pela equipe de saúde de um hospital infantil". *Revista Brasileira de Enfermagem* 63.1 (2010): 84-90.
8. Reis Jaqueline Farias dos. "A implantação de alta qualificada em um hospital universitário como apresentada ao processo da integralidade no cuidado". São José do Rio Preto s.n. Artigo Aprimoramento Profissional/SES, elaborada na Fundação Faculdade Regional de Medicina Hospital de Base de São José do Rio Preto e Faculdade de Medicina (2015).
9. Salci Maria Aparecida., *et al.* "Educação em saúde e suas perspectivas teóricas: algumas reflexões". *Texto and Contexto Enfermagem* 22.1 (2013): 224-230.
10. World Health Organization. "The Ottawa charter for health promotion". Ottawa Canada: WHO (1986).
11. Ferreira HP., *et al.* "O impacto da doença crônica no cuidador". *Revista da Sociedade Brasileira Clínica Médica, São Paulo* 10.4 (2012): 278-284.
12. Silva Cristiane Maria da Costa., *et al.* "Educação em saúde: uma reflexão histórica de suas práticas". *Ciência and Saúde Coletiva* 15.5 (2010): 2539-2550.
13. Do Amaral Anna Karenina Martins., *et al.* "Educação em saúde: aspectos históricos no Brasil". *Journal of the Health Sciences Institute* 31.2 (2013): 219-223.
14. Figueiredo Maria Fernanda., *et al.* "Modelos aplicados às atividades de educação em saúde: [revisão]". *Revista Brasileira de Enfermagem* 63.1 (2010): 117-121.
15. Corry Margarita., *et al.* "A systematic review of systematic reviews on interventions for caregivers of people with chronic conditions". *Journal of Advanced Nursing* 71.4 (2015): 718-734.
16. Angelo Jennifer K Egan and Richard Reid Kate. "Essential knowledge for family caregivers". *International Journal of Palliative Nursing* 19.8 (2013): 383-388.
17. Lucia Giuliani., *et al.* "Caregivers' Perception of Time in Palliative Care: A Metasynthesis of Qualitative Studies". *International Journal of Nursing Critical Care* 2.1 (2018): 5.

18. Oliveira William Tiago., *et al.* "Vivência do cuidador familiar na prática do cuidado domiciliar ao doente crônico dependente". *Ciência, Cuidado e Saúde* 11.1 (2012): 129-137.
19. Draganov Patrícia., *et al.* "Andragogia em saúde: estudo bibliométrico". *Escola Anna Nery* 15.1 (2011): 149-156.

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