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Nurses' knowledge and practice on social participation in health

Saberes e práticas de enfermeiros sobre a participação social na saúde

Saberes y prácticas de enfermeros sobre la participación social en la salud

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ABSTRACT

Objective: to identify nurses' knowledge and practice in the framework of the Family Health Strategy program with regard to social participation in health. **Method:** qualitative study which had the Family Health Units in a municipality of Minas Gerais as setting. Nine nurses participated in the study, and they were interviewed individually in July and August 2014. Data were collected and analyzed according to the content analysis technique and interpreted in the light of Paulo Freire's ontology and critical pedagogy. **Results:** the analyzed statements showed that nurses bring along conceptual and behavioral inconsistencies which need to be equalized, so their knowledge and practice can mediate the challenging construction of participatory management in health. **Conclusion:** an improvement in nurses' training is suggested, both academically and professionally, aiming at strengthening their political role in the process of consolidation of social participation in the Brazilian Unified Health System.
Descriptors: Nursing; Social Participation; Unified Health System; Family Health Strategy, Qualitative Research.

RESUMO

Objetivo: identificar os saberes e práticas do enfermeiro da Estratégia Saúde da Família com relação à participação social na saúde. **Método:** pesquisa de natureza qualitativa que teve como cenário as Unidades de Saúde da Família de um município de Minas Gerais. Participaram nove enfermeiros, entrevistados individualmente, nos meses de julho e agosto de 2014. Os dados coletados foram analisados segundo a técnica de análise de conteúdo e interpretados à luz da ontologia e pedagogia freireana. **Resultados:** os depoimentos analisados evidenciaram que os enfermeiros trazem incoerências conceituais e também atitudinais que necessitam ser equalizadas, a fim de que os seus saberes e práticas possam mediar a desafiadora construção da gestão participativa na saúde. **Conclusão:** sugere-se um incremento na formação do enfermeiro, tanto acadêmica quanto em serviço, no sentido de fortalecer o seu papel político no processo de consolidação da participação social no Sistema Único de Saúde.
Descritores: Enfermagem; Participação Social; Sistema Único de Saúde; Estratégia Saúde da Família; Pesquisa Qualitativa.

RESUMEN

Objetivo: identificar los saberes y prácticas del enfermero de Estrategia Salud de la Familia respecto de la participación social en la salud. **Método:** investigación cualitativa, con escenario en las Unidades de Salud de la Familia de municipio de Minas Gerais. Participaron nueve enfermeros, entrevistados individualmente, durante los meses de julio y agosto de 2014. Los datos recabados fueron analizados mediante técnica de análisis de contenido, e interpretados a la luz de la ontología y pedagogía freireana.

Resultados: los testimonios analizados evidenciaron que los enfermeros cargan con incoherencias conceptuales y de actitud que necesitan solucionarse, a efectos de que sus saberes y prácticas puedan mediar en la desafiante construcción de la gestión participativa en la salud. **Conclusión:** se sugiere profundización de la formación del enfermero, tanto académica como laboral, en pos de fortalecer su papel político en el proceso de consolidación de la participación social en el Sistema Único de Salud.
Descriptores: Enfermería; Participación Social; Sistema Único de Salud; Estrategia de Salud Familiar; Investigación Cualitativa.

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INTRODUCTION

The implementation of the Unified Health System (SUS, as per its acronym in Portuguese) has brought a different outline to health care in Brazil, with social participation, as regulated by the Act 8142/90, being a major cornerstone to be put into practice, in accordance with universality, equity and comprehensiveness of health services and actions[1].

The Family Health Program (FHP) was created in 1994 and included the principles of SUS, emerging as a new paradigm of health care, currently named Family Health Strategy (FHS) [2]. It is based on actions that are aimed at meeting families in the region, identifying health problems and risk situations in the community, carrying out the local planning based on people's life context, creating connections between professionals and users, and making them have joint responsibility in the resolution of their health problems[3].

In the FHS, nurses have the possibility to create an effective connection with the community, where they are found in a privileged space for dialog between the population and the State, which is an essential condition for the social construction of health. In this context, we find social participation, which refers to the concept of citizenship and social rights, to values of collective use, to the role of the State and to the relationship between State and society, which must be built to achieve the so-desired democratic management. Social participation is engaged with actions that come from different directions and social players, with the aim of influencing the creation, execution, inspection and evaluation of public policies and/or health services[4].

The Family Health Strategy is characterized by a direct contact between the team and the individual, the family and the community, allowing professionals to learn ways of acting together with the population and mediating the strengthening of democracy and user's autonomy, which is the context social participation is found[5].

On this assumption, we understand that, beyond educational, assistance and managerial aspects, the political dimension is implied in nurses' professional practice. It is up to them to learn, participate, have a say, decide and intervene on the social and political dynamics contained in the scope of health care actions. From that point of view, such dimension is included in their practice and identified by their ability to mobilize social groups, in order to meet the population's health needs[6].

The empirical observation of practice shows that nurses' political action is undermined as far as their performance is concerned in the promotion of social participation within the SUS.

Assuming that the nurses' importance as a mediator of community mobilization, and considering that this mediation is not being observed in practice, the following questions guided the present study: What do nurses understand by social participation within the SUS? Do they play the role of social participation mediator within the FHS? What have they been doing to mobilize users toward social participation in the health field?

The present study is of great importance in the current health setting, especially because of the 25th anniversary of the SUS regulation in 2015. In this context, nursing is committed ethically, politically and socially to defend social participation, fighting for the implementation of guidelines and proposals approved in the 15th National Health Conference. Assuming that this SUS principle is built from the micropolitics of the work process in health, this study tried to understand the knowledge and practice of FHS nurses with regard to social participation in the SUS.

METHOD

This is a qualitative study set in the Family Health Units (FHU) of a municipality in the state of Minas Gerais, which has a population of 57,390 inhabitants[7] and 14 family health teams composed of the minimum number of FHS professionals. The participants of the study were the nurses who made up those teams.

The first contact with participants was made by a telephone call, through which one of the researchers explained the objectives of the study and inquired about their interest in participating in the study.

As an inclusion criterion, it was established that participants had to be nurses who had been working in the FHS of the municipality for at least six months, as we believed that, in order to answer the questions, they had to have a certain link with the community, and therefore, be able to reflect on their performance in popular participation at the SUS.

Fourteen nurses were contacted, of which one refused to participate and three did not meet the inclusion criterion, totaling nine participants. Those who agreed to be included in the study were informed about the study objectives and stated their will to participate by signing a free and informed consent form. Interviews were scheduled on days and times of their preference, and were conducted in the health units in which they worked.

Data were collected in July and August 2014, by means of a semi-structured script with the following open-ended questions: What do you understand by social participation within the SUS? What have you done as a Family Health Strategy nurse to build social participation within the SUS?

Their permission was requested as to the use of recorders during the interviews, so their statements could be recorded in full, and then transcribed and analyzed. For the purpose of characterizing participants, the following details were collected: age, gender, length of service at the FHS, whether they graduated or not, and if so, in which field.

To ensure anonymity, participants were identified by the initial letter N, as in nurse, followed by the number corresponding to the order in which interviews were conducted, i.e. N1... N9. Data were divided into theme categories and subcategories, based on the main ideas contained in statements given by interviewees, and were analyzed according to Laurence Bardin's content analysis[8].

The analysis operation was based on steps described by the framework adopted: pre-analysis, material exploration, treatment of results obtained and interpretation. These steps started with the careful and repeated reading of interview transcriptions. According to the objectives of the study, relevant excerpts were chosen for the subsequent creation of theme categories. The interpretation of the material was carried out based on the connection of results with scientific evidence regarding the topics, with Paulo Freire's ontological and pedagogical approach as theoretical framework.

The present study was approved by the Human Research Ethics Committee of the Federal University of Viçosa (UFV), with a favorable opinion under number 689.568 of June 17th, 2014.

RESULTS

Nurses interviewed were 27 to 58 years old. Eight of them were women and one was a man. The minimum length of service at the FHS was one year and two months, and the maximum length was 15 years. Eight participants were graduated. All of them were specialized in public health or related areas.

The analysis of statements resulted in the emergence of two categories that revealed, respectively, the knowledge and practice of nurses regarding the object studied. "The meaning of social participation within the Unified Health System", which was the first category of the study, was divided into two subcategories: "Social participation as the community accession to services provided" and "Social participation related to social control in the Unified Health System". The second category, "Nurses' work in the context of social participation", was divided into the subcategories "Seeking alternatives to increase community participation in actions performed by the health care staff" and "Intermediating spaces of social participation".

The meaning of social participation in the Unified Health System

Nurses who participated in this study showed discrepancies with regard to knowledge about social participation. Such principle was either misunderstood or understood in accordance with its regulations.

Social participation as the community accession to services provided

Some nurses understood this SUS principle as the community participation in actions provided by the FHS team, with emphasis on the users' accession to educational activities aimed at the different stages of the life cycle:

> *I think it is the community participation regarding the services we provide here at the primary health care unit* [...]. (N4)

> [...] *social participation in the SUS is when the population connects with us* [...] *by participating of actions we provide, and also by making their contribution, I think that's it.* (N5)

> *It is the community participation in the work performed by the unit, such as the groups Women's Health, Workers' Health, Children's Health, Adults' Health* [...]. (N7)

Social participation related to the social control in the Unified Health System

Other nurses understood social participation as the population involvement with decisions that concern public health policies, in spaces to which they are entitled, such as the Municipal Health Council and Health Conferences:

> [...] *for me, it is the population participation in the development of public policies, by attending municipal councils* [...] *people participating in decisions made in the health sector, for health purposes*. (N2)

> [...] *it is social mobilization, from both the SUS by involving the population, and the community itself with regard to what is happening in the Family Health Program* [...] *it is the users' participation in the Municipal Health Council meetings* [...] *the involvement and active participation of the community in decisions related to health* [...]. (N3)

> [...] *it is the participation of society in decision making of public policies, by means of active participation in health councils and conferences* [...]. (N6)

Nurses' conceptions of social participation in the SUS are perceived in their practice in the context of the FHS, as shown in the second category.

Nurses' work in the context of social participation

Actions carried out by nurses with regard to social participation in the SUS include the search for alternatives in order to increase community participation in actions provided by the service and the intermediation of spaces of social participation.

Seeking alternatives to increase community participation in actions performed by the health care staff

When asked about practices related to the promotion of social participation, nurses reported enabling communication channels for people to express themselves. In this context, they emphasize the educational activities that they consider to have a potential ability to bring the community to the service and favor the linkage process. They relate such potential to a greater participation of the community in the service:

> [...] *We create a lot of groups* [...] *we provide a ballot box, through which users may report any problem, so I think they can express their feelings and complain* [...]. (N4)

> [...] *we try to get close to the community, to clear doubts that can make this approach difficult, to provide recreational work and bring the population close* [...]. (N7)

> [...] *we try to provide actual health education, to see whether we can attract people and make them participate.* (N9)

Still concerning actions taken, nurses suggest the extension of service hours to the evening, aiming at broadening community participation in services provided:

> [...] *for the population to receive the services we provide here, I try to have my service groups in the evenings* [...] *we now have appointments in the evening, which is for people who cannot come during the day* [...]. (N5)

> [...] *we have group meetings in the evenings, to see whether people will participate more* [...]. (N8)

In addition to the alternatives presented above, nurses mention other mechanisms they use to promote social participation in the framework of the FHS, on the grounds of a coherent perception, as presented in the following subcategory.

Intermediating spaces of social participation

Nurses stated that they continuously try to act as conveyors of this SUS principle. This is achieved by trying to consolidate formal and informal spaces of social participation, namely the local health councils and community meetings.

> [...] *we have been trying to reactivate the local health council to act more effectively in social control, in social participation* [...]. (N2)

> [...] *there are people in the community whom we see as leaders, who help everybody, who are a reference in the streets. So we always look for and meet them to support us* [...]. (N3)

Despite the fact that the meaning of social participation and the ways to achieve it are understood, it is worth highlighting how nurses fit into this context. The next statement refers to a notion of control of the popular participation process in which this professional draws up for themselves decisions that should be taken collectively:

> [...] *I hold Local Council meetings. I have a counselor who discusses with me what she sees as a barrier here, what the population is complaining about, and then I try to change it.* (N5)

DISCUSSION

It is evident that knowledge and practice mentioned by the participants of this study suggest diverging perceptions with regard to the actual meaning of social participation. They are anchored in participation as the users' accession to services provided and as the promotion of actions aimed at including users in the decision-making of the health sector. The conceptual fragility expressed by participants is alarming, due to their training history, with undergraduate and graduate degrees in the health sector or related areas obtained after the SUS regulation.

The literature shows that the evidence of this study can be found in other settings. A study conducted in Santa Catarina, Brazil, showed that the studied family health team considers this SUS principle as the community participation in services, such as lectures. Another interpretation associates social participation with democratic management in the SUS, mediated by talks and hearings with the community regarding their demands in the health sector[10].

When nurses conceive social participation as the community accession to services provided and unfold such conception into practices aimed at bringing users to health services – such as educational groups and the extension of service hours to evenings – they propose, in that spirit, to increase user access to health services, which does not necessarily mean including them in the context of social participation.

Such conceptual fragility expressed by participants can be transcended. Considering the unquestionable importance given to educational actions carried out in the FHS routine, it is understood that, depending on the health professionals' approach, an important means of communication can be created to speak to users about their right to health, which includes participating actively in the SUS construction[11].

This ability to transcend what is established is in line with Paulo Freire's ontological approach. By considering human beings as a social subject truly capable of "being more", he affirms men's inherent potential to transform themselves and change their social reality, from the process of raising awareness, mediated by their relationship with the others[9].

Based on this ontology, Paulo Freire built his own pedagogy. In the light of this, social participation can be understood from a dialogical point of view, which gives social subjects access to the process of awareness of the reality in which they are found. Dialog enables substantiating subjectivities, and makes way to an actual process of awareness intertwined with intersubjectivity. When men bring up the substantiation of subject matters in a collective context, that is, in a world where they interact with each other, they are led to raise awareness of the world, by seeing themselves as subjects who recreate and transform it, assuming the role of authors of their own story[9].

For nurses who do not understand the concept of social participation, it is important that they experience the awareness of this SUS principle in their social realities, so they are provoked by the reality to be transformed and are able to mediate a dialog that fosters the construction of social participation. This encounter of awareness refers to the awareness of different social players who act in the framework of the FHS and reshape this setting.

It is understood that communication is an important element for social participation in this context, since it is related to the ability of engaging an intelligible dialog with users. This

will contribute to the real access to information, which can support a trend of autonomy and empowerment of users, with education in health as the main strategy of action[4].

If professionals go that way, their theoretical fragility regarding social participation can be reshaped in their work routine. However, if the distorted understanding of this principle remains, this fragility will be a complicating factor for the achievement of social participation in health services[10].

Conceptual mistakes regarding popular participation in health highlight the urgent need for theoretical discussions that awaken the interest of nurses about a reflection on the real meaning of social control. From that perspective, we see continuous education, which has its ideological matrix in line with Paulo Freire's pedagogy, and is based on the questioning of reality and on the transformation potential of work in health[12].

The great challenge of continuous education is to encourage health professionals to raise awareness of their situation, so they can be continuously committed to improve their thinking and daily actions. For this attempt to be successful, we highlight the importance of basing this educational process on effective learning, in which professionals can be supported by senses in the search of (re)significations of their knowledge and practice that are part of their work routine[12].

Knowledge and practice of FHS nurses that are consistent with the real meaning of social participation were expressed in the statements that refer to their roles as conveyors of social participation spaces. When they understand it in light of participatory management, they try to promote it in their daily work, especially by fostering community participation in formal spaces for the performance of social control, such as health councils.

However, it must be observed that for social mobilization to occur, a liberating dialog process between professionals and users is imperative. In the absence of empowered citizens, council meetings become bureaucratic events and do not represent an effective participatory action[13].

Therefore, it is relevant to question how nurses have been placing themselves in the context of popular participation, although they have their own conceptual appropriation of this principle. The results of the present study also show that, despite they consider themselves to be conveying social participation spaces in the framework of the FHS, these professionals centralize/control such spaces, which can make it difficult or even prevent users or other people from expressing themselves. Such fact represents a space for monolog, not dialog, and neglects the liberating condition of subjects and the transformation of reality.

To this regard, Paulo Freire states that monologs, which are the monopoly of an expressed knowledge, are men's denial, and makes the subject's conscious expression impossible. If consciousness exists, it is not closure, but opening instead. Only dialog may enable an encounter between social subjects and awareness of their roles. Dialog is the tool that establishes the essential human intersubjectivity, of relational nature, in which no one has an absolute initiative[9].

The mediation of a liberating dialog is one of the main challenges health professionals have to face. Although dialog, humanization of care, relationships, hospitality in health care services and community empowerment are much valued, the authoritarian dialog still exists, and is line with what Paulo Freire calls "banking education"[14].

Therefore, for spaces of popular participation to become actual means of strengthening social control, it is necessary to develop democratic practices in health, since participation is not only a content that can be disseminated, but rather a concept and behavior to be built through dialog, critical reflection and citizens' growth[15].

Such reflections may be encouraged among health professionals who work in regions where people live, the matrix structure that sets up the meaning of community and which needs to be understood as a powerful social space for achieving the SUS principles[16].

In that sense, beyond formal spaces of popular participation, we must highlight those that emerge from the existing dialog held among different social players found in the region. They need to be identified by nurses, so as to promote an encounter and an effective dialog among citizens of the community located within the area covered by the FHS. Thus, informal spaces of social participation emerge, and this was also mentioned by nurses of this study as a strategy they try to apply in their work routine.

With regard to informal meetings held with the community, they do not represent a constitutionally defined space, since they are not institutionalized and regulated by the State, which is an essential condition to achieve participatory management. In spite of that, such spaces cannot be put aside, since they are appropriate spaces for sharing knowledge and experiences among professionals and the community, and they represent an incentive for exercising citizenship and committing to formal spaces of participation[17].

Therefore, actions carried out by FHS nurses are an important incentive to social mobilization, mediated by a dialog among society, workers and management. From that perspective, we should highlight the key political role played by nurses, in the sense of broadening and strengthening the foundations of citizenship and democracy in the framework of the SUS[18].

In light of the results of the present study and Paulo Freire's theoretical framework, it is possible to observe that knowledge and practices of FHS nurses need to be continuously based on a dialectical unit between users and themselves, so as to enable the principles of social participation. Only a liberating dialog can build solidarity awareness, by means of an encounter of subjectivities of social players in the health sector[9].

Such dialectical unit is the common thread of the political dimension of care, which is to be built by nurses in their professional practice. When they take over this responsibility, nurses contribute greatly in collective subjects' training who, once they become aware, may take a critical look at health reality, aiming at changing and implementing it in the so-desired SUS democratic management.

Therefore, we consider that, in order to better understand and put popular participation and social control into practice, health professionals must review and reassess their roles continuously, as well as the concepts they create, the

organizations to which they belong and health actions they take. Only dialog held among different social players of the health sector can lead to SUS consolidation, which is in an ongoing process of opening to change and new possibilities[17].

Considering that this study was conducted in a given municipality, with a specific group of nurses, the findings describe a particular reality, which can differ from other settings and subjects, and this makes the mainstreaming of results impossible.

FINAL CONSIDERATIONS

Bearing in mind that the SUS has participatory management as the ideological matrix, which is anchored in social participation as the system's organizational principle, the present study brings about relevant implications for nursing, as it encourages reflections on nurses' knowledge and practice with regard to building this principle in the FHS work routine.

Paulo Freire's ontological and pedagogical perspective enabled us to understand that the driving force for achieving popular participation is the liberating dialog that should be held between nurses and the other health players, including users. Based on the Freire's conception of dialog, nurses can effectively take on their political role to arrange the encounters of consciousness, which is the common thread to criticality, concern and transformation of reality by subjects who are part of it.

The findings of this study show that nurses bring along conceptual and behavioral inconsistencies which need to be equalized, so as their knowledge and practice can mediate the challenging construction of participatory management in the SUS. Such evidence must be highlighted in the framework of nurses' training, in both undergraduate and graduate courses, since all participants were specialized in public health or related areas.

This study also suggests that investments in continuous education be made, since it is a necessary space for nurses and other FHS professionals to build praxis that enable them to progress in the consolidation of popular participation.

Finally, we recommend that further studies be carried out from a qualitative perspective, aiming at extending the possibilities of reflection on nurses' role in the construction of social participation within the SUS.

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