Abstract

Background: The ageing population is one of the hardest challenges for current public health. However, for proper attention to the elders, the development of reachable social and health policies consistent with the real needs of this population is essential. Thus, this research aimed to analyse the perceptions of nurses about health education for the elderly, drawing upon the conceptions of Paulo Freire.

Method: This descriptive study utilised a qualitative approach conducted in the city of Juazeiro do Norte, Ceará, Brazil within the Unidades de Saúde da Família - USF (Family Health Units). Eighteen nurses participated in this study. A semi-structured interview was used for gathering data that was analysed according to content. The analysis of the obtained data began with the conception by Paulo Freire and from some relevant articles related to the topic.

Results: Considering the concept of health as a tool to develop people, in this sense some professionals associated health education as being focused on knowledge exchange, behaviour changes, and decision making in health, matching the Freirean ideology of questionable methodology. However, some professionals had a different understanding of health education, focusing on the concept of health, grounded in the absence of a disease, thus characterising a learning bank methodology as they resorted to vertical transmission of knowledge. However, the educational actions performed by those professionals envisioning healthy ageing were directed from the identification of prevalent diseases within the community.
Conclusion: Health education is the instrument that enables change in behaviour and decision-making in health care for the users, but it should be planned in an ongoing manner, considering the needs of the population, using methodologies that promote dialogue - an essential element for establishing the necessary link for conducting practical aspects given the perspective of health promotion.

Keywords
Health Education. Senior’s health. Health Promotion

Introduction
The ageing population is one of the hardest challenges for current public health, especially in developing countries where this phenomenon occurs with great social inequality. Demographic transition is the main factor for growing old, which was once only seen in developed countries, but currently is also found in developing countries like Brazil. However, in Brazil the phenomenon appears quite differently from that observed in developed countries, where the process of ageing occurs within a favourable socioeconomic context [1]. One of the challenges of this century is to support quality of life for the elderly population, mostly from a low socioeconomic and educational level, with a high incidence of chronic and disabling diseases. However, for proper care of the elderly combined with the magnitude and severity of the functional problems, the development of reachable social and health policies that are consistent with the real needs of this population is essential [2].

In this context, the actions of health education can achieve health promotion. According to a study by Sousa [3], health education is an instrument for promoting quality of life for people, families and communities through the articulation of technical and popular (mass) knowledge, of institutional and community resources and of public and private initiatives. This conception surpasses the biomedical concept of health care and covers a wide range of determinants of the disease-care-process. Therefore, these educational actions can be a tool for improving the quality of life of the population. In particular, there is an intrinsic connection with the promotion of elderly health, since along with the ageing process some changes occur in the person, in the areas of organic structure, metabolism, biochemical balance, immunity, nutrition, functional mechanisms, emotional and intellectual conditions, and even in communication itself [4].

Hence, it is essential that the nurse, the professional who acts within this context, develop the strategies for health education since it is necessary to have a full understanding about health and quality of life, valuing the local population’s history of life, stimulating self-confidence, practicing solidarity and developing practical attitudes of citizenship, expanding scientific knowledge to facilitate more critical thinking [5]. It is also necessary that professionals consider the ageing process as a multifaceted reality, in which the biological, social, cultural, psychological and genetic variables must be considered, in particular, for the development of care to this population segment [6].

According to the same authors, the educator is responsible for collaborating with the students in organising their thinking, encouraging them to identify their learning needs through reflection and...
dialogue, in an effort to be critically aware of their needs making them the agent of the social transformation. It is necessary that the act of teaching is not the act of depositing, narrating, transferring or transmitting knowledge and values to students, but a knowledge act that makes problem-based education possible which suggests overcoming the contradiction in education [7].

But before these aspects are discussed, some questions arise: Do nurses perceive the actions of health education with the perspective of transforming the individualistic view of health, strengthened by the biomedical paradigm, for more collective dimensions, as problem-based education, in order to promote active development in old age? Are these actions planned based on the needs of the elderly or do the professionals impose them?

It was important to make the nurses from Family Health Strategy look for an approach to recognise which elements are present, and, if these correspond to health promotion. Thus, the aim of this research was to analyse nurses’ perceptions about health education for the elderly, according to the conceptions of Paulo Freire, which has its assumptions based on the premise that education is the construction of knowledge, appreciation of the active subject and reflection, leaning on concepts such as education as an act of production and construction of knowledge and as a practice of freedom [7].

Taking into consideration the specificities of the ageing process and the need for adequate and professional qualification, as well as the possible gaps in the training of health professionals, this research aimed to contribute to the discussion about educational activities of nurses towards the elderly population in the sense of offering them a better quality of life.

Methods
This descriptive study used a qualitative approach and was performed in Juazeiro do Norte, Ceará, Brazil, with nurses from the Family Health Units of this municipality. The qualitative approach, according to Bardin (2009), arises due to the impossibility of investigating and understanding some phenomena comprising perception, intuition, and subjectivity by means of statistics.

Also according to the author, this approach works with a plethora of reasons, meanings, aspirations, beliefs, values, and attitudes - all corresponding to a depth of relationships, processes and phenomena that cannot be reduced to the operationalization of variables. Given that this research sought professionals’ and users’ reality, involving interpretations of the relationship of meanings related to health education activities, seeking the experience of the study’s informants regarding the working process towards implementation of these actions, a qualitative approach was appropriate.

The informants of the study were nurses working for the Estratégia Saúde da Família – ESF (Family Health Strategy), with a total of eighteen (18) interviewed, seventeen (17) female and one (1) male, all of them having 2 to 10 years of experience in this field. Data collection was conducted from October to December 2013.

We stopped collecting data upon reaching saturation. Data saturation refers to when the researcher realises that no new information relevant to the research question arises during interviews [8]. Data collection was conducted by the researcher with the help of students from the Scientific Initiation of a public institution in Cariri, Ceará - Brazil, where the researcher is a docent. Before data collection, the research was explained to the participants and they signed a consent form freely agreeing to participate. The participants were contacted for interview scheduling. The interviews were conducted before or after nursing consultation. They were recorded for about 20 minutes and transcribed by the researchers.

For data collection, a semi-structured interview and a checklist were used to approximate the stu-
died reality. The data were organised using content analysis [9], wherein they were arranged into stages to evaluate the meaning behind the words. Thus, upon the initial reading, the corpus of the research consisted of 18 nurse interviews. After the corpus construction, data were operationalised with codes, unit records, and subsequently identifying contextual units. After the construction of these units, two categories were constructed. Finally, the categories were organised and interpreted in light of the theoretical framework of Paulo Freire. To ensure participants' confidentiality, the nurses were identified as 1-18.

The research followed all the rules established by Resolution 466/12 of the National Health Council [10], which regulates research involving humans. The project was submitted the research ethics committee, receiving approval under protocol number 195 428.

**Results And Discussion**

From the initial reading, the 18 nurse interviews were organised by the researchers. Empirical material obtained from the field notebook included the following questions: What is the perception of health education in old age? What strategies are used? What methodologies are used for the planning of these actions?

After reading and interpretation, theme categories were created. The point of view of this group about health education in old age was expressed in the topics that follow, allowing us to create the following two categories: from banking to problem-solving education and education in pursuit of healthy ageing.

**From Traditional to Problem-Based Education**

Health education itself is a tool for construction and dissemination of knowledge and practices related to the ways each culture conceives of life in a healthy manner, as well as the production of subjects and social identities. Inserted into a model in which its main objectives are changes in health practices, aiming at health promotion, the nurses are one of the main professionals to consummate these practices from the actions of health education. Therefore, it is important that they hold a perception about health education, since it must be developed with users in the Unidades de Saúde da Família, which is an education focused on the needs of these users, dialogical, and should be perceived as a process of teaching and learning for decision making in health.

Accordingly, based on the statements, taking into account the nurses’ perception in this study, there was an understanding of health education focused on knowledge exchange, changes of behaviour, decision making in health as shown in the statements below:

*It is the practice of modifying a lifestyle to healthy habits through education.*

Nurse 1.

*Multiplication of knowledge. It is a process of teaching and learning.*

Nurse 4.

*[…] Health education means to transmit knowledge about a subject, for someone to participate in health care […] through interactions and exchange of knowledge and experience […].*

Nurse 7.

*[…] Health education is a process of exchanging knowledge and experiences among the population as a whole, including users, managers and health professionals. Each person is valued as an owner of specific knowledge, a learner and an educator. This practice aims at disease prevention, health promotion and promotes the autonomy of subjects […].*

Nurse 8.
[...] Transmit health information to an audience in order to change the lifestyle of a patient [...].

Nurse 15.

However, among some professionals, health education was still quite focused only on the absence of disease:

Vulnerable groups who are guiding and explaining how to prevent diseases for some kinds of people like: elderly, pregnant women, women of pregnancy age, adolescents, people with chronic diseases.

Nurse 2.

[...] Health education and the way you prevent diseases.

Nurse 10.

As shown in the statements above, although professionals perceive health education from the perspective of teaching and learning, they still revealed a certain inconsistency of viewing health as an absence of disease and a distant model of education related to the patterns of the ESF, which aims to reconstruct practices toward health promotion.

A large diversity of models in health education exist and those can be categorised into two main areas: the traditional or preventative model and the radical model. The traditional model of health education emerges from an understanding of health as being an absence of disease and a proposal of educational strategies guided by biomedical assumptions [13]. In this context, health education aims at transforming educational practices in the health area that previously predominated: disease prevention. To promote health and therefore the radical approach to health education, the focus on disease prevention is not enough, and must be seen as a set of actions among many sectors that broaden its scope. Utilising multidisciplinary activities allows for direct interaction with the population and at the same time an exchange of experiences among the professionals involved in this process [11-13].

Thus, the workers involved with health care must be aware that health promotion is distinguished from prevention, although they complement each other in relation to the health-disease process. The focus of health promotion is broader as it seeks to check out, confront and transform the macro-determinants of the health-disease process toward health. Prevention is aimed at people becoming free from diseases [11].

Considering these conceptions, according to Freire’s perspective, this is called banking education and problem-based education, which can be understood as a traditional education when it relates to the banking one, and problematizing education when it relates to the radical one. Problem-based education opposes the practice of banking education. In the ‘banking’ approach to education, the ‘knowing’ is a donation from those who are called “wise” to those who are expected to know nothing. Donation is founded in one of the material manifestations of the oppression ideology – the absolutism of ignorance that constitutes what we call alienation of ignorance; accordingly, this one can be found within the other [14].

Knowledge, in this pedagogical practice is transferred from teacher to student by imposition. With oppression at its core, it does not require a critical awareness of the subjects involved, and keeps a distance between the teacher and student who is never challenged to construct knowledge. This model of education refers to the banking one because the student passively receives the knowledge [14]. In banking education, the teacher is the holder of knowledge, observing a vertical relationship between educator and educating. The educator transfers contents to the student who becomes the object that receives the knowledge. Turning students into alienated passive subjects is a typical model of an oppression system. [14]
In problem-based education, a chance for dialogue, communication, problem discovery, questionings and reflections about the manner of things are a given. Education becomes an act of knowing; it aims at a transformation for it is a critical education. Both teacher and students are standardised by the world and the reality that they learned and where they extract the content from learning [14]. It is believed that criticality implies growing humankind’s appropriation of its position within this context. It implies its insertion and the objective representation of reality. This is why consciousness is the development of awareness [15].

Given this comprehension, it is evident that when nurses perceive health education as a tool for decision-making through the exchange of experience from the perspective of health awareness they contemplate, at least in theory, a health education leading towards promotion. This reality approaches the ideas of Paulo Freire, by revealing a concern about the knowledge of users, with their experiences.

On the other hand, when referring to health education only as being a focus on diseases it ends up looking like a punctual activity, providing fragmented and ready-made actions, imposing information and not building knowledge with the community. Thus, it reveals a traditional education, within the perspective of a banking education.

In this sense, it is necessary for nurses to realise that the concept of education in health as separate from promotion of health can mean only punctual actions, not achieving changes in behaviour. According to the changes in the population’s life expectancy, increasingly professionals will be facing the elderly population, which physiologically will pass through changes, and because of this, they will need specialised care. Thus educational activities for this population are exceedingly required, highlighting the promotion of healthy ageing through educational actions that guide the elderly and other individuals to preserve health and improve their functional abilities by adopting healthy lifestyle habits and the abolition of unhealthy behaviours.

The pursuit of education for healthy ageing

One of the biggest challenges that Brazil will face in the coming decades will be the public health cost of an increasing aging population. This takes place via two main factors: the increasing longevity of the elderly and the increasing use of health services by the elderly [16]. Thus, it is understood that health professionals, including nurses, have to reorient their practices to approach the needs of this population. In this context, we sought to understand the practices of these professionals in search of healthy ageing through educational activities. For these professionals to construct these actions, they considered only the diseases prevalent in the community, as illustrated by the following lines:

“Actions towards diseases, medications, risk factor, power [...]”
Nurse 11.

“Meetings to identify issues raised by the elderly; their complaints.”
Nurse 12.

“Since the needs expressed by the population.”
Nurse 13.

It was revealed that the activities are provided only to those who seek the services or for those who already have the disease. Additionally, the actions in clinical nursing are reduced and there are little innovative methodologies for care in health education.

“During the nursing consultation [...]”
Nurse 1.
Usually I gather groups of hypertensive patients and diabetics who are served first week, second rounds.

Nurse 3.

Daily practice all queries, I do not transcribe I guide everyone, diabetic or Leprosy [...].

Nurse 8.

They are performed at the time of consulting both medical or nursing, mainly the groups of hypertensive and diabetic [...].

Nurse 9.

Among the various forms of nurse’s actions in modern society, educational practice appears as the main strategy for health promotion. It is noteworthy that nurses are educators prepared to propose and provide strategies to enable changes in people/communities [17]. As a part of the multidisciplinary team of the ESF, there is the Agente Comunitário de Saúde – ACS (Community Health Agent - CHA), which is considered to be the link between the health team and community with its main objective as the transmission of scientific knowledge to the community, facilitating user’s access to health services.

Two basic attributes of social agents are appointed: identity with the community and a vocation for solidarity aid, which allied with their leadership skills, render them as a mediator between two spheres: the State and community [18]. Therefore, considering their training, as the authors showed above, they are still a result of technical training, which may contribute to the discourses of nurses when they revealed that the actions in this category focus on the diseases as based on the information from the ACS.

Thus, when the statements related to these nurses’ perceptions are confronted with health education, a gap in the field of practice with theory is noticed, once they say that the educational activities are conducted for diabetes, hypertension, for example, they end up promoting preventative actions turned to health indicators and not to the needs identified by users. Such practices sustain traditions of hierarchy and user-professional models of normalization and medicalization [19]. It should be emphasised that educational actions constitute a range of situations which characterise the delivery of services to the population and that the involvement of all the actors is an unequalled condition for the full exercise of public health [20], practices that provide seeking not just the disease, but the population health needs. This health education deviates from an education based on the perspective of promotion because it focuses only on the disease and not on the conditions of life and health of the population.

Facing these aspects, it is noteworthy that in the studies by Paulo Freire this kind of education in which the teacher brings ready-made content, without regarding knowledge or the reality of others, ends up being an imposed, punctual education. Comparing this with the current models of health education, it is characterised as hospital-centred, since it works only with a focus on disease, healing and prevention. In this sense, it is proposed that dialogue must prevail in this educational process, with interaction, so these actions can be built, which corroborates Freire [14] when he states dialogue engages the educator-learner to walk along together, allowing a greater understanding of life experiences and a more critical conception of reality. So both are positioned like subjects from the act of knowing.

A different education is desired, an education of partnership which targets not making the student an object of manipulation, but to create a joint experience of different realities in an exchange of elements in a relationship of mutual transformation [15]. Thus, it is seen that dialogue is the key concept and the essential practice in Freire’s conception. Dialogue is fundamental in the construction process and in the formation of a human being since
humankind is a strong keeper of some significant knowledge, no matter the social class and neither age nor education. Dialogue makes humankind critical of the world it lives in [14].

As observed in the testimonies of nursing as a ready-made education, a necessary dialogue for planning these actions to fulfil the needs of users is lacking. The dialogue is essential for implementation of educational activities. Persons who dialogue with each other open themselves up for a new kind of knowledge and know there is something to discover and interpret.

In this context, it is emphasised that nurses are educators and they need to understand that dialogue must happen, and that dialogue is essential for understanding the needs of users including the elderly, since with them it is essential to engender confidence and maintaining a healthy state of high value. Facing this reality, health education is a tool for nurses to promote health for this population; however, nurses need to be aware that the knowledge about the patient’s health is essential for a successful outcome [21].

In this understanding, in studies of health education for the elderly, dialogue is one of the essential elements for building a healthy environment for intervention in the context of old age. For this purpose, it is necessary that health professionals and managers to develop creative education programmes for health [13, 22]. It is evident that nurses are already seeing the educational activities as a tool to propose changes in behaviour, however, it was still noticed that although inserted in a model of attention for health care in the country with principles and guidelines aimed at promoting health, they understood these educational activities as being of prevention, restricted to the concept of health facing the absence of disease, which is reflected in the conduct developed by them. These conducts were characterised as punctual and fragmented, far from the context of the population, in this case, the elderly ones.

This coincided with the Freirean vision of radical education, where the elderly become passive persons who only receive information with actions focused on health indicators, focused on the index related to diseases that affect this population and not on real health needs.

However, the results point to the practices of nurses in search of healthy development, actions that are not determined by needs identified through dialogues with the elderly, but from indicators or some information gathered by other professionals. Thus, we cannot think about a banking education, imposed, ready-made, but about an education that encourages changes, which builds up knowledge, making users a type of critical people, aware and able to make the right decision to achieve better conditions for life and health.

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Conflicting interests
The authors declare they have no conflicting interests.

List of abbreviations
FHS - Family Health Strategy
SUS - Unified Health System
ACS - community health agents
UBS - basic health unit

References


