From the (in)visibility of the education for sexual reproductive health to the production of knowledge in nurse practice

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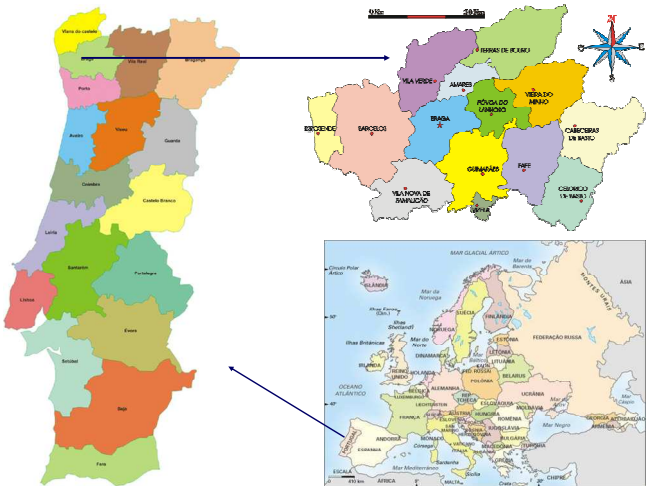
INTRODUCTION

In the International Conference on Population and Development (ICPD) Program of Action, *Reproductive health* is defined as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.* In that Conference, a Programme of Action (the Cairo Consensus) focused on empowering women and meeting people's needs for education and health, including reproductive health. Contrary to what used to happen not so long ago, today in Portugal the women are precociously accompanied by health professionals among whom gives advice and even more and more frequently gives adequate formation on how to live in a healthy and balanced way during this period of their lives. On the other hand, many attitudes and behaviors of the woman, normally part of a family, are also associated to this wide and in a way complex context.

Geographically this study was limited to the areas of Braga, Vieira do Minho and Vila Verde, which are located in the north-eastern region of Portugal.

Figure 1 – Social context at study



AIMS

In this perspective, we intend with this study to learn the importance given by women to the health education concerning the consultation of Family Planning and identify the elements that influence the fulfilled practices.

METHODS

This study is based on a qualitative paradigm. Half-structuralized interviews were carried out on 50 women and eight midwives. Concerning the sample, we can characterize it as a sample by convenience (number reached for the saturation of data). The analysis of content was done according to the perspective of several authors (E.G. R. Bodgan E S. Biklen, 1994, L. Bardin, 1995; J. Poirier, 1999; M. Minayo, 2001)

RESULTS

Socioeconomics sample characterization

Midwives Characterization

The 8 Midwives are working in a Primary Centers. All interviewed play functions in Reproductive health consultations by choice, and was an area that gives some job

satisfaction. Their ages were between 37 and 42 years, with an average age of 46 years when considering the length of service, we found that this varies between 12 to 37 years, being the average 24.5 years. They have a long professional experience. In category nurse specialist (midwives), we found that two nurses play functions two years ago, four ten years ago, one for 30 years and another for 32 years.

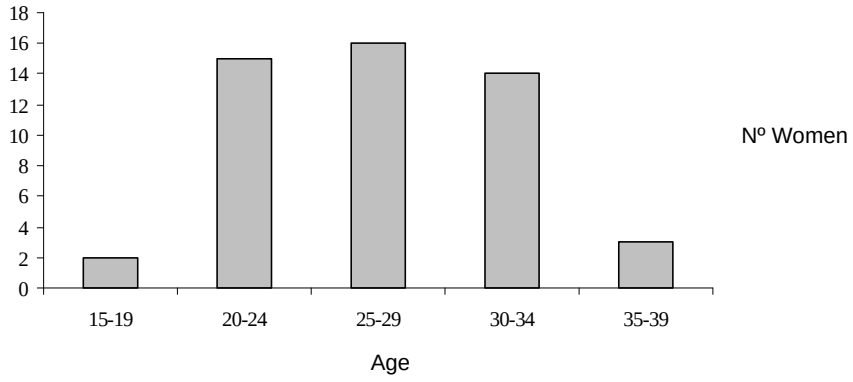
Figure 2 – Midwives professional characterization

	Time as a Midwife	Time of service (Years)	Time in care unit (Years)
Nurse/Midwife 1	10	19	9
Nurse/Midwife 2	2	12	5
Nurse/Midwife 3	10	22	6
Nurse/Midwife 4	10	27	9
Nurse/Midwife 5	2	25	22
Nurse/Midwife 6	32	37	32
Nurse/Midwife 7	30	32	30
Nurse/Midwife 8	10	22	22

Source: Own Elaboration.

The women ages vary between 18 and 37 years whereas the average in 27 years (Figure 3). 37 of fifty women interviewed were married, 4 women were unmarried, 7 lived together and 2 were divorced.

Figure 3 – Women age



Source: Own Elaboration

Health Education Importance

The nurses/midwives were unanimous in stating that Education for Health is a priority activity (Figure 4). However, it is important to point out that there was a certain dissonance between the data mentioned by the midwives. In their consultations, they spoke about three themes (Figure 5).

Figure 4 – Midwife role in the consultation of Reproductive Health

The Midwife role
To clarify about the advantages of regular fecundity
To inform about the advantages of spacing pregnancies
To elucidate the consequences of an unwanted pregnancy
To inform about the anatomy and Physiology
To provide scientific information, complete and free of all contraceptive methods (their advantages, disadvantages and the degree of effectiveness for the spouses to choose the method that suits, always respecting their religious)

Source: Own Elaboration

Figure 5 - Health Education Themes

Health Education Themes	n
Contraception	10
Self breast examination	5
Vaginal Cytology test	5

Source: Own Elaboration

Midwives practices are divided into two models which we designate as traditional and dialogic (Figure 6). The first model points to the prevention of diseases and damages in accordance with the information of biometric contents in order to reduce individual risks. The second is focused on the individual and its reality, thus considered as subject of the educational practice.

Figure 6 – Comparison between two Models of Health Education

Characteristics	Hegemonic Model	Dialogic Model
Conception of education.	Depositing of knowledge and values.	Act of knowledge in relations with the world and in communion with others.
Conception of health	The absence of disease.	Social production of health-disease process.
Conception of man: users	Devoid of knowing or misguided knowledge carrier or harmful to health, this is the subject of educational practice.	Bearer of knowledge and practice of health and care acquired through concrete experiences of life; subject of educational practice.
Conception of man: professionals.	Holders to technical-scientific know as a status of truth; he has nothing to learn of rapprochement with the popular know.	Holders of a scientific technical know that it is unfinished; daily, their actions are made by a dialogue with people's knowledge.
Focus of educational practice in health.	Focused on disease; emphasis strictly the prevention.	Based on people who resort educational practice using promotion as mainly method.
Objectives	Decrease of individual risk, prevention of diseases and health injuries.	Constitution and transformation of health conditions and improvement of life quality.
Spaces educations.	Lack of unity between educational practices and the others health practices, formal like educational groups.	Integration between health care and education, informal contexts of interpersonal relations.
Methodologies	Unilateral and informative communication; lectures; brochures; posters, etc...	Dialogic communication: problematization and reflection.
Point of departure	Scientific knowledge; Diagnostics of needs by health professionals using epidemiological surveys.	Objective reality and conditions of existence of assisted; co-participation and co-responsibility in the diagnosis of problems.

Source: Alves (2004)

CONCLUSION

From the information gathered we have concluded that the nurses were unanimous in stating that health education is a priority activity. However, we confirmed that there was not a complete match between the information mentioned by the nurses and the information given out by the women as well as between the observations of the developed educational practices.

The midwives educational practices in Basic Health Care are performed in a superficial way due to reduced consultation time.

But the nurse/midwives acts in a way that enables the woman to grow and helps her adapting to the transitory transformations of health, guiding her and favouring each of the stages of the process of resolution of the problem, but without making the decisions for her and never replacing her role.

These are part of what we call the traditional and dialogical models. So, it is important to question how schools should teach their health professionals concerning this purpose.

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