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GROUP EDUCATIONAL ACTIVITIES ON SEXUALLY TRANSMITTED INFECTIONS: CONVERGING CARE RESEARCH IN A MENTAL HEALTH UNIT

ATIVIDADES EDUCATIVAS GRUPAIS SOBRE INFECÇÕES SEXUALMENTE TRANSMISSÍVEIS: PESQUISA CONVERGENTE-ASSISTENCIAL EM UNIDADE DE SAÚDE MENTAL

ACTIVIDADES EDUCATIVAS GRUPALES SOBRE INFECCIONES DE TRANSMISIÓN SEXUAL: INVESTIGACIÓN CONVERGENTE-ASISTENCIAL EN UNA UNIDAD DE SALUD MENTAL

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ABSTRACT

Objective: Objective: to evaluate the impact of educational health activities on Sexually Transmitted Infections (STIs), from the perspective of the professional team of a mental health unit. **Methods:** Convergent-Assistance Research, with a qualitative approach, developed with professionals from a mental health unit in a Teaching Hospital. The research phases were developed from June to September 2018 through educational group actions, participant observation and semi-structured interview. **Results:** three thematic categories were unveiled: "Knowledge and clarification about STIs", "Actions about STIs: professionals' view" and "Possibilities for reflections and self-care in front of STIs". **Conclusion:** the study pointed to new participatory possibilities of health education regarding STIs in a mental health environment, demonstrating the impact of these actions for professionals, for patients with mental disorders and for the (re) organization of the service, as well as in the collective construction new care practices and theoretical-practical learning.

Descriptors: Sexually transmitted diseases; Health education; Mental health; Nursing.

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RESUMO
Objetivo: avaliar o impacto das atividades educativas em saúde sobre Infecções Sexualmente Transmissíveis (IST's), na perspectiva da equipe profissional de uma unidade de saúde mental. **Método:** Pesquisa Convergente-Assistencial, com abordagem qualitativa, desenvolvida com profissionais de uma unidade de saúde mental de um Hospital de Ensino. As fases da pesquisa foram desenvolvidas no período de junho a setembro de 2018 por meio de ações grupais educativas, observação participante e entrevista semiestruturada. **Resultados:** três categorias temáticas foram desveladas: "Conhecimentos e esclarecimentos acerca das IST's", "Ações sobre IST's: olhar dos profissionais" e "Possibilidades de reflexões e autocuidado frente às IST's". **Conclusão:** o estudo apontou para novas possibilidades participativas de educação em saúde referente às IST's em ambiente de saúde mental, demonstrando o impacto destas ações para os profissionais, para os pacientes com transtorno mental e para a (re)organização do serviço, bem como na construção coletiva de novas práticas assistenciais e de aprendizados teórico-práticos.
Descritores: Doenças sexualmente transmissíveis; Educação em Saúde; Saúde mental; Enfermagem.

RESUMEN
Objetivo: evaluar el impacto de las actividades educativas en salud sobre las Infecciones de Transmisión Sexual (ITS), desde la perspectiva del equipo profesional de una unidad de salud mental. **Métodos:** Investigación Convergente Asistencial, con enfoque cualitativo, desarrollada con profesionales de una unidad de salud mental en un Hospital Escuela. Las etapas de investigación se desarrollaron de junio a septiembre de 2018 mediante acciones educativas grupales, observación participante y entrevista semiestructurada. **Resultados:** Se dieron a conocer tres categorías temáticas: "Conocimiento y aclaraciones sobre las ITS", "Acciones sobre las ITS: visión de los profesionales" y "Posibilidades de reflexión y autocuidado frente a las ITS". **Conclusión:** el estudio indicó nuevas posibilidades participativas de educación para la salud sobre las ITS en un entorno de salud mental, demostrando que estas acciones tienen impacto tanto para los profesionales, los pacientes con trastornos mentales y la (re)organización del servicio, como para la construcción colectiva de nuevas prácticas asistenciales y aprendizajes teórico prácticos.
Descriptores: Enfermedades de transmisión sexual; Educación para la salud; Salud mental; Enfermería.

INTRODUCTION

Before the Psychiatric Reform took place in Brazil, people with mental disorders were confined to asylum institutions, in inhuman and unhealthy conditions/spaces, and treated with little scientific basis and with treatments that were often aggressive. The care that was part of the institutional routine produced poor quality of life for patients and stimulated aggressiveness.[1] Since then, there have been significant changes in care, management and policies related to mental health care: the model of hospitalization and asylum incarceration opened space for the development of a broader care that

considers human rights as part of the therapeutic process.[2]

Thus, mental health care is seen differently, as it values the way of living and feeling of these people and their singularities and specificities as human beings. The new humanized forms of care, therefore, respect the individual conditions of the health-disease process and enable interaction with the family and society, in addition to encouraging these individuals to become protagonists of their own history.[3]

Mental disorders impact individuals in different ways, from emotional aspects and psychic and/or psychosomatic effects to the most serious ones, such as personality disorders. As a result, there is, in general, a certain difficulty related to the field of self-care, particularly with regard to sexuality, considering that this population has an active sexual life and presents risky behaviors, a problem that challenges mental health professionals.[4]

In this sense, these people are more vulnerable to sexually transmitted infections (STIs), which occur through sexual intercourse without the use of condoms, and also vertically from mother to fetus, in the case of syphilis and the Human Immunodeficiency (HIV). These infections can result in and changes in lifestyle, in addition to being a public health problem worldwide.[5-7]

Given the epidemiological transition of recent years and the increase in STIs, sexual health education actions are needed in mental health services. A multicenter study[8] carried out in 11 public hospitals and 15 public mental health clinics in Brazil, identified high rates of STIs in general and, specifically in relation to HIV, higher rates among people with mental disorders than in the general population; it also revealed that most of the institutions surveyed did not have sexual health education actions or condoms available.

The concept of health education considers that health is the result of factors interconnected, directly or indirectly, to the social context, corroborating the condition of physical, mental, social and spiritual well-being.[9] In this way, the process of educating in health must lead to taking into account basic living conditions, such as education, income, work, housing, basic sanitation, security, leisure and access to health services, and has the potential to result in improvements in people's lives. Thus, the proximity to these conditions impacts the quality of life of people with mental disorders, and the exchange of knowledge during this health education process creates a bond between professionals and users of the Public Health System.

In view of the above, the question is: what is the impact of health education actions related to STIs in a mental health unit of a teaching hospital? The general objective of the study was to collectively build health education actions related to STIs in a mental health unit. For this moment, one of the specific objectives will be presented, namely: to evaluate the impact of health education actions related to STIs, from the perspective of the professional team of a mental health unit, as inducers of changes in care practice.

It is understood, therefore, that the study on this topic can provide subsidies for more effective care actions in this population group, especially in health education, in the promotion of care and in the prevention of STIs. In addition, the topic is configured as a priority for health research and is based on the National Agenda of Priorities in Health Research.[10]

METHOD

This is a Convergent Care Research (PCA), with a qualitative approach, since it sought to converge care, research and the active participation of those involved in the practice scenarios, aiming at a reflection and production of knowledge about the assistance phenomena. The PCA provides for the participation of the researcher supporting the local team in the scenarios of care practice with a view to, starting from a theoretical renewal, develop (new) knowledge, build other technologies and/or propose new ways of caring.[11]

Thus, PCA was developed in its five phases, from planning to data interpretation.[12] The conception phase involves the definition of the PCA problem from a meeting between the researcher and healthcare professionals for its determination.[12] The phases of the research were developed from June to September 2018 through educational group actions, participant observation and semi-structured interview. A meeting was then held in June 2018 with professionals from the Madre Madalena Mental Health Unit, from Hospital Casa de Saúde, located in the city of Santa Maria, Rio Grande do Sul, Brazil. At this moment, an increase in cases of patients with STIs in the service and a difficulty on the part of the team in approaching the subject dialogically and assistentially was reported.

The instrumentation phase operationally guided the researcher in terms of defining the study scenario (Mother Madalena Mental Health Unit), participants (health professionals and users), data collection techniques (educational group actions, participant observation and interview semi-structured) and data analysis

(qualitative analysis). It should be noted that for the development of PCA specific methods and techniques of investigation are not necessary, as long as the researcher pursues the main objective of this type of research, which is the renewal of care practice.[12]

The study was developed in an inpatient unit that consists of 25 beds for the mental health treatment of the adult population affected by mild and moderate disorders. Twenty professionals participated in this study, including: a nurse, three social workers, two psychologists, an occupational therapist and 13 nursing technicians. According to the PCA, all professionals involved in the problem must participate in the study; thus, it was defined by the participation of those who had been working in the unit for more than six months, as they made possible greater contributions to the understanding of the phenomenon and modification of care practice. Those who were on vacation, reports and/or certificates during the PCA period were excluded.

The scrutiny phase, although presented separately for didactic purposes[12], is interrelated with the instrumentation and analysis phases, as it refers to the moment when, in an intense and detailed way, the researcher is committed to the simultaneous development of the technical and theoretical knowledge. In the psychiatric inpatient unit, then, the following care activities were developed by the researcher: construction of health indicators; provision of rapid testing for the detection of HIV, syphilis and hepatitis; and, reception and guidance during the care process of carrying out the tests, in order to guide on the prevention of other STIs.

In an articulated, simultaneous and almost concomitant way with the previous stage is the analysis phase, and, for that, the data collection and construction process was guided by the following research techniques: educational group actions, participant observation and semi-structured interview. In this sense, and in view of the problem of STI's in the mental health scenario, raising a series of other thematic interfaces (subjective desires, sex and sexuality, empowerment, understanding capacity, possibility of negotiation with the partner, access preventive methods, among others), it was decided to start PCA with educational group actions.

To guide the group action, a container, called the “truth box”, was installed as a way of collecting and analyzing the doubts arising from the participants in order to organize the meetings in order to contemplate their questions. The researcher, three days before

the group activity, accessed the box to organize the subsequent meeting, which was planned to last at least 30 and at most 40 minutes. This is because, if the meetings exceeded this time, the patients showed restlessness, no longer participating collaboratively and dialogically in this moment of health education.

Participant observation was carried out throughout the development of PCA with a view to enabling the recording of situations, actions, behaviors, care relationships, distances and approximations that coexist in the care scenario among health professionals, between professionals and patients and among the patients themselves. The semi-structured interviews took place in the unit itself, in a room with privacy for the professional to expose their speech in order to effectively contribute to the proposal. The interview is a privileged communication method that makes it possible to understand the reality experienced by the participants through their information, facilitating the understanding of the investigated theme.[13]

Thus, the interview was based on an instrument composed of two parts, the first of which collected the participants' identification data for the design of their profile. The second part presented specific questions about the study theme, allowing participants to spontaneously answer the questions. The following questions constituted the script: "What is the importance of health education actions in the context of STIs in a Mental Health Unit?", "How do you perceive the actions in this unit?" and "What is your opinion about the changes that have taken place to the detriment of the actions taken?". On average, the interviews lasted 40 minutes.

Finally, the interpretation phase closes the PCA and requires from the researcher an intellectually intense and deep work with a view to synthesis (identification of the main actions, attitudes, behaviors and dialogues referring to the problem in focus and systematization into categories), theorization (inter-relationships with the existing theoretical framework on the subject) and transfer (dialogical feedback with users and care professionals and changes/improvement/adaptations of nursing care).[12]

The results of the process resulting from the educational group actions will be presented in this article, since the professionals were encouraged to express themselves, in writing, after carrying out these approaches. The main purpose was to verify the feelings and understandings regarding this care-investigative moment, as well as the perceptions about the alterations and changes that were present in

the scenario of care practice. The participants' manifestations during the actions were recorded by the researcher and are presented coded (P1, P2... P20). Also, for a better understanding, categories were elaborated by approximation and similarity to present the results.

The ethical aspects of research with human beings were respected, according to Resolution nº 466/12 of the National Health Council.14 The study was approved by the Ethics Committee of the teaching institution under protocol nº 2,696,372.

RESULTS

From the compilation of the manifestations of the professionals after the educational group actions, three categories were revealed: “Knowledge and clarifications about STIs”, “Actions on STIs: professionals' view” and “Possibilities for reflection and self-care in the face of STIs”.

Knowledge and clarifications about STIs

Mental health professionals reported the desire for meetings, meetings, a space where they could participate in discussions to acquire knowledge and resolve doubts regarding STIs, as follows:

There is a need for a space for discussion about what STIs are, treatment and especially information on prevention. However, in addition to that, it is important to promote a space for reflection on sexuality, providing a listening to the insecurities and anxieties on this topic. Understanding sexuality not only from a biological point of view, but also from a social, historical and affective point of view. (P1)

It is extremely important for users, since many of them are not aware and, from these spaces, it was possible to learn, as well as exchange experiences, new doubts arose, which were later explained. I also emphasize that such actions were useful for post-discharge reflection, in the sense of changing their actions later. (P11)

It is very important, because from the actions on STIs, it was possible to clarify doubts and questions from users and even from professionals at the unit. (P17)

The statements reveal the concern of professionals with the possibility of patients becoming infected with STIs, that it is necessary to talk about sexuality and that these themes are little discussed in the care reality. On the other hand, it is clear that the actions implemented were enlightening, productive and reflective.

Actions on STI's: professionals' view

Health education actions were cited by the unit's professionals as beneficial to the routine, as they meet the essential and mandatory activities of health institutions,

not being different in the context of hospital mental health. The statements below clarify this understanding:

It is a differentiated look, a humanized care for our users who, for the most part, are excluded from health services and public policies. (P8)

The actions were constructive as users had the opportunity to clarify doubts and learn how to prevent STIs. (P10)

I believe that these actions in the unit are essential and contribute to the treatment of the patient who is hospitalized. As well as for the professionals who work in the unit, it is fundamental, since it promotes knowledge, clarification and information about the topic that can later be passed on. (P19)

The importance of health promotion and education in the context of mental health is highlighted and, in particular, in the subject of STIs, given that professionals understand them as another humanized form of care. They also mention that these actions help in the process of in-service education.

Possibilities for reflection and self-care in the face of STIs

This category presents some of the reflective possibilities emanating from professionals about health education actions and also the issues inherent to self-care in the face of STIs. These reflections are punctuated below:

In relation to the changes, it can be seen that there was a greater interest of the patients in debating and talking about the topic, as well as several doubts that they had. Patients reported that based on this new information and clarification, they realized the importance of prevention and self-care. (P1)

I believe that they will take with them the learning (what has been passed), will know how to identify symptoms and, also, will be multipliers of information. Ex.: we had a professional sex user in the circle, it was certainly relevant to her life. (P5)

According to some listening carried out, it was possible to observe changes in care, prevention and knowledge of patients. (P13)

The professionals realized that the health education actions led to changes in the patients' self-care, that they felt more encouraged to clarify their doubts related to STIs and that they had the possibility of becoming multipliers, in the family and in the community, of this information.

DISCUSSION

Mental disorder, for a long time, was considered something demonic or a natural evil, that is, all behavior that did not fit the normative pattern of the time(s) was understood as a deviation that should be hidden, excluded. Currently, many of these people still live on the margins of society and end up, countless times, being excluded from coexistence and daily activities.[1] As a

result, even today, comprehensive health care for this population is not offered in a systematic way, which can be translated, for example, by the lack of sexual health education actions in mental health institutions.[4]

According to a study[15], the lack of encouragement and implementation of continuing education in hospital mental health environments impact on the strengthening of the mechanization of care and on the difficulty in maintaining a singular look at the care of these people. On the other hand, health education actions offered to professionals working in these services strengthen the bond with the user, and between the user and the family.

In this context, health education promotes a deconstruction of imposed cultural beliefs that permeate mental health and stigmatize these people. The stigma that this person experiences is related to the health service they attend, the criticism received by family members and the loss or reduction of work activities during the hospitalization period, situations that actually impact their relationship with society. Therefore, to be inserted in the social context, this person needs to develop credibility in their therapeutic accompaniment, in order to lead their own life process.[16]

Thus, professionals, when contemplated by health education actions, have subsidies to empower themselves and, consequently, offer comprehensive, humanized and more effective care for people with mental disorders[15], when considering all the dimensions that make up their being. In addition, the way in which the mental health user adheres to treatment and health care has a certain relationship with the bond established with the service professional, with success or failure being linked to the health education process, which can guarantee comprehensive care for people with mental disorders.

The production of health education actions in a group activity - based on PCA - in an environment of mental hospitalization enabled the construction of dialogic spaces that resulted in the training/updating of health professionals, in the dissemination of knowledge, clarification and information to users and professionals and in a restructuring of care practices and the care scenario itself. Health education was used as a “transforming vehicle for individual practices and behaviors, and for the development of the user's autonomy and quality of life”.9:481

It is known that in the process of professional training, knowledge about STIs is developed and improved in clinical care in general. As a result, professionals

often do not associate this specific knowledge with mental health activities, which is also related to the historical denial of sexuality in this population.4 Another investigation[17] identified that professionals have difficulties in addressing these issues in the health area, mental illness and, generally, they forget about the possibility and vulnerability that people with mental disorders have in being infected with some STI.

Thus, when developing health education actions, in addition to providing knowledge and information from up-to-date scientific sources, a meeting mediated by dialogue is also possible, which has the potential to increase the bond between the members of the health team and between them and the patients.

In this sense, educating professionals in the perspective of STIs stimulates a reflective and critical look, qualifying the care process. Therefore, the mental health professional exchanges knowledge with users in a way that learns and teaches during the performance and, then, stimulates not only technical knowledge, but also the role of the user[18] in relation to the understanding of their body, their sexuality, of their vulnerability to STIs, of self-care demands and of their potential as a multiplier of this information.

Another aspect to be considered is the understanding that users have about STIs, since, based on this understanding, self-care actions will take place, including measures to protect and prevent STIs. Self-care is related to people's autonomy and the user's ability to (re)define their desires, rules and limits. This happens through human interaction, being, in a way, the result of the relationship between the health professional and the user, and the user with his family.

Health education establishes a vital component in care in order to promote health through educational practices, whether individual or collective, ensuring the exercise of citizenship after hospital discharge. Learning sexuality through conversation circles and dialogic encounters facilitates users' understanding and ability to practice STI prevention proposals, living sexuality in a complete, healthy and stigma-free way.

In the professional context, it is noteworthy that health education actions stimulate the team in a context of responsibilities and updating needs, considering the service, work, care, education and quality of care, fundamental elements in daily practice professional; with this, the process of caring for and educating users becomes easier.[19] The reality observed in this mental health unit reveals how much the person who experiences a

mental disorder needs, in addition to family support and the social context, a care that contemplates more than just issues related to the disease, but that considers the various aspects that constitute their being.

CONCLUSION

The study pointed to possibilities of health education actions and demonstrated the impact of these actions for professionals, patients with mental disorders and for the (re)organization of the service, as well as in the collective construction of new care practices and theoretical-practical learning. Still, it was possible to reflect on the subject, rescuing its importance and signaling the need for comprehensive and human care in mental health care settings.

Through PCA, it was possible to contribute to the care provided to mental health users, since the professionals participated in educational-assistance moments that provided them with subsidies for a more effective and welcoming care. Added to this, this study made it possible to work on a theme that was, until then, incipient in the reality of that health service, and which may help to develop future research.

It is understood as limitations of the present study the fact that it did not apply a scale to measure the potential and limitations of group activity, as well as not having quantified the impact of the actions developed, which restricted possible comparisons and generalizations. Thus, investment in interventional research with evaluation of effectiveness is suggested.

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