



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

EDUCATION HEALTH PATIENTS WITH BLOOD HYPERTENSION: PROFESSIONAL CONCEPTS OF PRIMARY CARE

A EDUCAÇÃO EM SAÚDE COM PORTADORES DA HIPERTENSÃO ARTERIAL: CONCEPÇÕES DE PROFISSIONAIS DA ATENÇÃO BÁSICA

LA EDUCACIÓN EN SALUD CON PORTADORES DE LA HIPERTENSIÓN ARTERIAL: CONCEPCIONES DE PROFESIONALES DE LA ATENCIÓN BÁSICA

Anderson Samuel Figueiredo¹, Johny Carlos de Queiroz², Lucidio Clebeson de Oliveira³, Fernando Augusto Alves de Mesquita⁴, João Evangelista Menezes Júnior⁵

ABSTRACT

Objective: to analyze the understanding of the multidisciplinary team of health education practices in everyday work and its importance in the prevention and control of hypertension. **Method:** a descriptive qualitative study carried out with eleven professional team three of the Family Health Strategy (ESF), in the rural area Antonio Martins, RN/Brazil, from a semi-structured interview. The project was approved by the Research Ethics Committee (CEP), CAEE 0066.0.428.000-09. **Results:** it was found that the health education practices developed by the team are very ignorant and the methodologies used are made of prescriptive and hierarchical way. **Conclusion:** there are needs to restructure health services and training for the entire staff of the ESF, as well as greater availability of physical resources and appropriate material support. **Descriptors:** Nursing; Arterial Hypertension; Health Education.

RESUMO

Objetivo: analisar a compreensão da equipe multiprofissional sobre a prática de educação em saúde no cotidiano do seu trabalho e sua importância na prevenção e controle da hipertensão arterial. **Método:** estudo descritivo com abordagem qualitativa realizado com 11 profissionais da equipe três da Estratégia de Saúde da Família (ESF), da zona rural do município de Antônio Martins, RN/Brasil, a partir de uma entrevista semiestruturada. O projeto foi aprovado pelo Comitê de Ética e Pesquisa (CEP), CAEE 0066.0.428.000-09. **Resultados:** constatou-se que as práticas de educação em saúde desenvolvidas pela equipe são muito insipientes e que as metodologias empregadas são realizadas de forma prescritiva e hierarquizadas. **Conclusão:** é necessário que haja reestruturação dos serviços de saúde e capacitação de toda a equipe da ESF, assim como maior disponibilidade de recursos físicos e materiais de apoio adequado. **Descritores:** Enfermagem; Hipertensão Arterial; Educação em Saúde.

RESUMEN

Objetivo: analizar la comprensión del equipo multiprofesional sobre la práctica de educación en salud en el cotidiano de su trabajo y su importancia en la prevención y control de la hipertensión arterial. **Método:** estudio descriptivo con enfoque cualitativo realizado con once profesionales del equipo tres de la Estrategia de Salud de la Familia (ESF), de la zona rural de la ciudad de Antônio Martins, RN/Brasil, a partir de una entrevista semi-estructurada. El proyecto fue aprobado por el Comité de Ética e Investigación (CEP), CAEE 0066.0.428.000-09. **Resultados:** se constató que las prácticas de educación en salud desarrolladas por el equipo son muy insipientes y las metodologías empleadas son realizadas de forma prescriptiva y jerárquica. **Conclusión:** es necesario que haya reestructuración de los servicios de salud y capacitación de todo el equipo de la ESF, así como, mayor disponibilidad de recursos físicos y materiales de apoyo adecuado. **Descriptor:** Enfermagem; Hipertensão Arterial; Educação em Saúde.

¹Student, Nursing Course, University of Rio Grande do Norte State/FAEN/UERN. Mossoró (RN), Brazil. E-mail: samukgomes@hotmail.com;

²Nurse, Master degree Professor in Nursing, University of Rio Grande do Norte State/FAEN/UERN. Mossoró (RN), Brazil. E-mail: johnycarlos@uol.com.br; ³Nurse, Professor Nursing at Work Specialist of FAEN/UERN. E-mail: lucidioclebeson@hotmail.com; ⁴Nurse, Nursing School, University of Rio Grande do Norte State. Mossoró (RN), Brazil. E-mail: fefegusto87@bol.com.br; ⁵Nurse. Nursing at Work Specialist. Professor of the Nursing Technician School Thereza Néo. Mossoró (RN), Brazil. E-mail: joaojuniormenezes@hotmail.com

INTRODUCTION

Along the history, the construction of educational activities was based on aspects of sanitary nature, directed to economically disadvantaged lower classes in order to control, supervise, monitor and combat epidemics. Health education was developed through purely informative educational practices based on pedagogy with informative and vertical features. These initiatives have caused resistance from the population, when the rise of compulsory vaccination and the revolt of the vaccine is an outstanding historical fact.¹

In Brazil, health education activities play a crucial role after the promulgation of the Federal Constitution of 1988 and the approval of Law 8080, which characterize health as “a right of all and duty of the state”. In addition, the principles of comprehensiveness, universality, fairness and autonomy become guiding elements of production of actions and services in the health sector.¹⁻²

In this perspective of social and ideological transformations, individuals' health is understood as an interactive and ongoing process between a number of conditioning factors and determinants in their way of life. Therefore, there is an overvaluation of the activities focused on the promotion, protection and restoration of health to the detriment of purely curative and occasional care.²

The Family Health Program (PSF) in this scenario is considered the gateway to the health system patients, but also an important instrument able to promote a new dynamic to the structure of health services, as well as its relationship with the community and between different levels of care complexity.³

At the same time, the educational practices are together with such transformations and become an essential communication link between the nurse and the patient, used as a way of knowledge about fears, anxieties, prejudices, that is the subjective needs of each individual. This interaction between the nurse and the patient confirms to develop skills of a humanized care and autonomous through qualified listening, welcome, emphasizing the uniqueness of each story, values, beliefs and subjectivity from an emancipatory educational practice.^{1,4,5}

In capitalist society and, more recently, postmodern, there is the prevalence of the relationship domination-exploitation between the subject and the appearance of alienating ways of life, separating the human being all

the individuality, feelings, wants, desires that prevent the realization actions that result in an adequate quality of life.

This social condition has risks and potential for the emergence of chronic degenerative diseases such as, high blood pressure.

The Arterial Hypertension (HA) currently represents a major public health problem in Brazil, the main population risk factor for cardiovascular disease that represent a major cause of deaths and hospital hospitalizations. In the unified health system (SUS), there are 1,150,000 of hospitalizations/year at a cost of about 475 million, with spending on highly complex procedures not included. However, 60-80% of cases can be treated in the primary care area.

In Brazil, the estimated prevalence of hypertension is about 20% of the population in adulthood, with 80% of cases associated with cerebrovascular accident (CVA) and 60% to the ischemic heart disease.

Arterial hypertension is a disease defined by the persistence of systolic blood pressure above 135 mmHg and diastolic above 85 mmHg and is now considered one of the main risk factors for cardiovascular and cerebrovascular disease. It is a multifactorial clinical condition characterized by high and sustained levels of blood pressure (BP). It is frequently associated with structural and/or functional abnormalities of the organs, such as heart, brain, kidneys, and blood vessels and metabolic changes, with a consequent increased risk of fatal and non-fatal cardiovascular events.⁶

When signs and symptoms are late, it is a major problem to be faced, and when they occur, they are usually indicative of lesions in other systems. Abnormally high pressures coursing most often asymptomatic mode echo slowly and steadily over the tissue so-called target organs (brain, heart, kidneys, retina and peripheral vessels), determining the classical complications of hypertension.⁵

The combination of this lack of symptoms and the patients' lack of knowledge about the disease favor the “misconception” to enjoy good health. Consequently, they will get lack of adherence to treatment and the possibility of aggravating the continuing development of hypertension. From there, the educative actions produced within the framework of primary health care arise in the perspective of the needs arising from the reality of people with patients of high blood pressure, being an essential tool for the prevention and promotion of health of these individuals.

Figueiredo AS, Queiroz JC de, Oliveira LC de et al.

Health professionals, especially in integral primary care, are responsible for social change, particularly to assistance to health of hypertensive patients, the nurse may be a multiplier agent of knowledge through health education promotion of patients, seeking to provide them to develop healthy habits of life, enabling greater acceptance of the disease and autonomy.

It is noteworthy that there is an educational health promoter model that allows extrapolation to the biological aspects of the disease and focus on the quality of life of the subject. Educational actions must be based on the full and individualized design of the health-disease, because besides the use of drugs, hypertensive treatment involves changes in lifestyle.

The health professional should be used for a liberating educational practice, having in essence the dialogical, and which enables the patient the knowledge in the treatment process. Encouraging awareness of their active participation as self-care builders. Obtaining knowledge of their health status and autonomy in their decisions.

Professionals should encourage the construction of educational practices based on a broader understanding of the health-disease process and recognize the complexity of the human condition. That is, a defocused education of pathology and directed to the quality life of the subject.

OBJECTIVE

- To analyze the understanding of the multidisciplinary team of health education practices in everyday work and its importance in the prevention and control of hypertension.

METHOD

Article elaborated from the dissertation *“Health education in hypertension: a strategy for improving the quality of life”* presented to the State University Nursing graduation course of Rio Grande do Norte (FAEN / UERN). Mossoró-RN, Brazil. 2010.

The research is characterized as a descriptive qualitative study. It is a descriptive research with qualitative approach because, at first, it was necessary to perform a data collection arising from the fact/phenomenon/process under study and also enter in the universe of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a deeper space of relationships, processes and phenomena that cannot be reduced to

Education health patients with blood hypertension...

operation variables of a certain reality, as well as the interpretation and analysis.⁸

The study was conducted at the Health Centre of the city of Antônio Martins, composed of thirteen health professionals working in the team three of the Family Health Strategy in the rural zone of the city, with the HIPERDIA program as a guiding element of professional activities.

It was chosen to work with the team three because professionals are working together with Hypertension patients, developing group activities aimed at the practice of health education with hypertensive patients for approximately two years.

Data collection was initiated after approval of the research by the Research Ethics Committee (CEP) of the University of Rio Grande do Norte State (UERN), manipulated by a semi-structured interview. For the purposes of data collection instrument, there was a previous contact with the ESF team to schedule date and time with the professionals to not interfere in the activities already planned by the Group.

The speeches were recorded on electronic device MP4, upon the consent of the participants, to achieve greater reliability of the data and therefore their confidentiality. Data were stored and/or filed in personal computer researchers for a minimum of five years.

Data analysis was based on a set of communication analysis techniques to obtain, procedures, systematic and description of the objectives of message content, indicators (quantitative or not) that allow the inference of knowledge about the conditions of production/reception of these messages.⁹

Therefore, for this analysis, data were organized into categories for a better understanding of its results. Categories seek to gather the information on common characteristics as well as the largest number of information at the expense of a layout and so correlate events classes to sort them. In the end, the organization of data into categories is the passage of the raw information to the information organized.⁹

After the research, in order to gain greater knowledge of the subject, the data collected will be analyzed/interpreted to an organization and systematization of information in attaining a thought on the subject under study.

This study has monitored the ethical principles of research involving human beings, developed respecting the ethical aspects established by the National Board of Health,

Figueiredo AS, Queiroz JC de, Oliveira LC de et al.

and the resolution of the nursing code of ethics. A consent form (TCLE) was prepared for the subjects involved in the research. To ensure confidentiality of the subjects, pseudonyms were assigned related to risk factors that influence the onset of arterial hypertension.¹⁰⁻¹¹

The research was approved by the Research Ethics Committee (CEP) of the University of Rio Grande do Norte State (UERN) number 073/09, CAEE 0066.0.428.000-09 protocol, being a research involving human beings, allowing permission for the dissemination of the results.

RESULTS AND DISCUSSION

• Health education strategy directed at people with high blood pressure

In the health education targeted for patients with hypertension, the public health policies built at the level of primary health care have been presented as the gateway for monitoring, compliance and improving the quality of life of patients. Thus, the challenge of materialization of educational actions with a view to implementation of health promotion is mainly of professionals involved in the family health strategy, being a privileged and priority space to establish links with these patients, enabling knowledge of their cultural and social diversities involved.¹²

Health education is very important for the whole community, after these health education practices we realized that people have improved greatly, greatly decreased the number of hospitalizations, people who lived very poorly today live better. Even the way people express themselves improved in that community (Nurse 1).

Health education is of great importance for these hypertensive people because it helps control high blood pressure, as well as assist in adherence to treatment and living with the disease, so that it does not bring them more complications (Nurse 2).

In this sense, it is understood that it is essential to use health education practices for hypertensive patients acquire the necessary knowledge about the disease, symptoms and the process of evolution, providing their active participation in the process, improving lifestyle, making them aware of the importance of adherence activities provided by professionals.

To account for the complexity of factors involved in the reality of people with high blood pressure, it is necessary to join efforts of all health professionals related to primary care, the main strategies to prevent these

Education health patients with blood hypertension...

diseases, their complications and health promotion, aiming a better quality of life.⁷

Health education is of paramount importance. With it we can guide people, but they need to have a follow-up not only by the health worker but also the nurse, the doctor, the dentist, to be developed in general, because it is not only our evaluation but the team as a whole (Nurse 3).

Therefore, health education practices carried out at the Health Unit, together with the Ministry of Health, should be performed by all the professionals who make up the team of ESF, from the perspective of an integral and continuous care for the whole community identifying risk situations, the determinants of health/disease process, developing educational processes for health aimed at improving self-care of these individuals. However, it is important to emphasize that it is still quite prevalent realities where the educational practices oriented processes change, are also developed with methods and activities intended only to convince patients to change their habits and adopt healthy behaviors being carried out by vertically integrated methodologies where approaches, the traditional model, centered on the disease in transmission information of scientific knowledge, normative and prescriptive about how patients should adopt their lifestyle to be healthy, without guided the construction of knowledge through a dialogic relationship.⁶

Health education actions of the multidisciplinary team are still guided in vertically integrated methodologies, hierarchical and prescriptive character, using lectures and passing on information as strategies.

Yes, the group work with guidance, lectures, distribution of medicines and blood pressure check. These guidelines are about diet, exercise, proper use of medication, so that they can improve some lifestyle habits. (Nurse 2).

We use some strategies in Health Education, for example, monitoring the patient in the office and in some cases in the household and lectures with information on hypertension and treatment of this disease. (Nurse 4)

In this scenario, it is realized that health education should act potentiating the actions of disease prevention and health promotion, based on reflective practices, enabling the patients being subject to historical, social and political articulated to his life context under the vision of a clinic expanded by health professionals.⁶

Figueiredo AS, Queiroz JC de, Oliveira LC de et al.

However, when we analyze the reality studied, health education activities are based on a “banking” model, whose relations are narrators and essay, that is education becomes an act of depositing, in which the teacher is the owner of the knowledge and the student is a “safe” empty. Thus, what exists is just a transfer of information.

In a biased and hegemonic context, the educational activities are notorious in the sense of passing on information to the public on major diseases seen in the health sector in which it emphasizes the so-called “prescriptions” on “right” or “wrong” behavior linked the diseases and their prevention.⁷

It is necessary that the health education practices are seen as an ongoing process of empowering individuals and groups, with the ability to promote ties between professionals and patients and not only specific actions.

Education as a social practice seeks social transformation from a critical and reflective view of reality of society. Thus, there should be practices based on participatory methodology, where the individual is co-participate in the construction of knowledge rather than simply transfer information.¹²

CONCLUSION

Despite the short time of implementation of health education practices in that service, it is clear that the realization of the developed educational initiatives are still incipient and there is a lack of a better basis about the concepts that guide the practice of health education for multidisciplinary team. By the vertical way how these actions are carried out, it was observed that there were improvements in the living conditions of people with hypertension patients. However, it became clear that these practices should be informed on a methodology of participation, as recommended by the Ministry of Health and underwent a process of transformation of a practice information transfer to a practice of construction of knowledge of individuals and groups, so that occurs transformation of lived reality, becoming a practice of social transformation.

It is necessary to be a multidisciplinary and interdisciplinary approach, not realizing just punctual and fragmented actions of health education. These actions should be undertaken from a critical view of the patients' reality, distancing from the simple transfer of information and content, with alienated speak about issues or speeches. Health education permeates scientific

Education health patients with blood hypertension...

knowledge covering experiences seeking to redirect the behavior of individuals, respecting their knowledge, values and knowledge acquired during life.

REFERENCES

1. Elaine AC, Valente GSC, Maria MA, Almeida VC, Chagas FS, Rosane AT. O Enfermeiro no gerenciamento da educação em saúde da estratégia saúde da família. J Nurs UFPE on line [Internet]. 2010 Apr-Jun [cited 2010 May 12];4(2):596-604. Available from: <http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/view/7059>
2. Brasil. Lei n.8.080 de 19 de setembro de 1990 e Lei 8082 de 1992. Dispõem sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União, Brasília, 1990. Seção1, p.18055 - 18059.
3. Menezes Júnior, Queiroz JC, Fernandes SCA, Oliveira LC, Coelho SQF. Educação em saúde como estratégia para melhoria da qualidade de vida dos usuários hipertensos. Rev Rene [Internet]. 2011 [cited 2010 May 12];12(spe):1045-51. Available from: http://www.revistarene.ufc.br/vol12n4_e_sp_html_site/a21v12espn4.html
4. Chiesa AM, Veríssimo MLOR. A educação em saúde na prática do PSF. Manual de enfermagem. Instituto para o desenvolvimento da saúde. São Paulo. Brasília: Ministério da Saúde; 2001.
5. Zabali PCLE, Martins LC, Fortesca P. O programa da família na busca da humanização e da ética na atenção à saúde. Manual de Enfermagem. São Paulo: IDS USP, 2001.
6. São Paulo(Estado), Secretaria de Saúde. Gabinete do Secretário. Secretaria Técnica. Manual de orientação clínica: hipertensão arterial sistêmica(HAS). São Paulo: SES/SP, 2011.
7. Brasil, Ministério da Saúde. Secretaria de Políticas de Saúde. Departamento de Ações Programáticas Estratégicas. Plano de reorganização da atenção à hipertensão arterial e ao diabetes mellitus. Departamento de ações programáticas estratégicas. - Brasília: Ministério da Saúde, 2001.
8. Deslandes SF, Cruz Neto O, Gomes R, Minayo MCS. Pesquisa social: teoria, método e criatividade. Petrópolis: Vozes; 1994.
9. Santos AR. Metodologia científica: a construção do conhecimento. 4ª ed. Rio de Janeiro: DP&A, 2001.
10. Nóbrega ESL, Medeiros ALF, Leite MCA. Atuação do enfermeiro no controle da

Figueiredo AS, Queiroz JC de, Oliveira LC de et al.

hipertensão arterial em unidades de saúde da família. J Nurs UFPE on line [Internet]. 2010 Jan-Mar [cited 2010 May 12];4(1):50-60. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/450>.

11. Lessa L. O adulto brasileiro e as doenças da modernidade: epidemiologia das doenças crônicas não transmissíveis. São Paulo: Hucitec; 1998.

12. Ministério da Saúde (BR). Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Hipertensão arterial sistêmica para o Sistema Único de Saúde. Brasília: Ministério da Saúde; 2006.

13. Loro MM, Kitzmann TS, Rosanelli CS, Kolankiewicz ACB, Poli G, Stumm EMF. Adesão ao tratamento anti-hipertensivo em portadores de hipertensão arterial sistêmica de uma unidade de saúde. J Nurs UFPE on line [Internet]. 2010 Oct-Dec [cited 2010 May 18];4(4):1595-603. Available from: http://www.unip.br/comunicacao/publicacoes/ics/edicoes/2012/04_out-dez/V30_n4_2012_p336a342.pdf.

14. Barros CMS. Modelo da atividade em educação em saúde. Serviço Social do Comércio, DN/DPD/GEP; 2006.

15. Santos AR. Metodologia científica; a construção do conhecimento. 7ª ed. Rio de Janeiro: Lamparina; 2007.

16. Minayo MCS. O desafio do conhecimento: Pesquisa qualitativa em saúde. 10ª ed. São Paulo: Editora Hucitec, 2007.

17. Bardin L. Análise de Conteúdo. Lisboa, Portugal: Edições 70; 2009.

18. Conselho Nacional de Saúde(CNS). Resolução 196, de 10 de outubro de 1996. Aspectos éticos da pesquisa envolvendo seres humanos. Brasília: Ministério da Saúde [Internet]. 1996. [cited 2010 May 18]. Available from:

<http://www.pppg.ufma.br/departamentos/comite-deetica/resolucao196.pdf>

19. Conselho Federal de Enfermagem(COFEN). Resolução 311, de 08 de fevereiro de 2007. Aprova a Reformulação do Código de Ética dos Profissionais de Enfermagem. Rio de Janeiro: COFEN [Internet]. 2007. [cited 2010 May 18]. Available from: <http://www.portalcofen.gov.br/Site/2007/materias.asp?ArticID=7221§ionID=34>

20. Ministério da Saúde (BR). Secretaria de Gestão Estratégica e Participativa. Departamento de Apoio à Gestão Participativa. Caderno de Educação Popular e Saúde. Brasília: Ministério da Saúde, 2007.

Education health patients with blood hypertension...

21. Freire P. Pedagogia da autonomia: saberes necessários à prática educativa, 25ª ed. São Paulo: Paz e Terra; 1996.

Submission: 16/06/2014

Accepted: 27/08/2015

Published: 15/12/2015

Correspondence

Anderson Samuel Figueiredo
Universidade do Estado do Rio Grande do Norte/UERN
Rua Almino Afonso, 478
Bairro Centro
CEP 59610-210 – Mossoró (RN), Brazil