HEALTH EDUCATION AS A TOOL IN THE PATIENT KNOWLEDGE WITH ARTERIAL HYPERTENSION

EDUCAÇÃO EM SAÚDE COMO FERRAMENTA NO CONHECIMENTO DO USUÁRIO COM HIPERTENSÃO ARTERIAL

EDUCACIÓN EN SALUD COMO HERRAMIENTA EN EL CONOCIMIENTO DEL USUARIO CON HIPERTENSIÓN ARTERIAL

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ABSTRACT

Objective: to analyze the health education actions of patients with Systemic Arterial Hypertension in the HIPERDIA program developed in the waiting room of the Family Health Unit. Method: this is a descriptive study with a qualitative approach, based on the action research, carried out with 20 patients of the HIPERDIA program. In the production of data, the semi-structured interview was used, and the data was analyzed in the technique of content analysis in the Thematic Analysis modality. Results: patients broadened the understanding regarding home care for better control of hypertension. However, in relation to pre-existing knowledge and did not identify changes. Conclusion: for the health education activities carried out at the second moment of the research, the same ones became insufficient because some factors such as age and educational level, some elderly people did not change their life habits for the control of SAH. Descriptors: Health Education; Systemic Arterial Hypertension; Waiting Room.

RESUMO

Objetivo: analisar as ações de educação em saúde dos usuários portadores de Hipertensão Arterial Sistêmica no programa de HIPERDIA desenvolvidas na sala de espera da Unidade de Saúde da Família. Método: estudo descritivo, de abordagem qualitativa, ancorada na pesquisa-ação, realizado com 20 usuários do programa de HIPERDIA. Na produção de dados, utilizou-se a entrevista semi-estruturada, sendo os dados analisados por meio da técnica de análise de conteúdo na modalidade análise temática. Resultados: os usuários ampliaram a compreensão em relação aos cuidados no domicílio para melhor controle da HAS, entretanto, em relação ao conhecimento pré-existente e realizado, não identificamos mudanças. Conclusão: as atividades de educação em saúde realizadas no segundo momento da pesquisa tornaram-se insuficientes, pois diante de alguns fatores como idade e nível educacional, alguns idosos não mudaram seus hábitos de vida para o controle da HAS. Descritores: Educação em Saúde; Hipertensão Arterial Sistêmica; Sala de Espera.

RESUMEN

Objetivo: analizar las acciones de educación en salud de los usuarios portadores de Hipertensión Arterial Sistémica en el programa de HIPERDIA desarrolladas en la sala de espera de la Unidad de Salud de la Familia. Método: estudio descriptivo, de enfoque cualitativo, basada en la investigación-acción, realizada con 20 usuarios del programa de HIPERDIA. En la producción de datos fue utilizada la entrevista semi-estructurada, siendo los datos analizados en la técnica de Análisis de contenido en la modalidad Análisis temático. Resultados: los usuarios ampliaron la comprensión en relación a los cuidados en el domicilio para mejor control de la HAS, sin embargo, en relación al conocimiento pre-existente y realizado no identificamos cambios. Conclusión: frente a las actividades de educación en salud realizadas en el segundo momento de la investigación, se las mismas se tornaron insuficientes, pues frente a algunos factores como edad y nivel educacional, algunos ancianos no cambiaron sus hábitos de vida para el control de la HAS. Descriptores: Educación en Salud; Hipertensión Arterial Sistémica; Sala de Espera.

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INTRODUCTION

Hypertension (AH) is considered one of the main health problems in Brazil today, increasing the medical-social cost, mainly by the risk factors, its complications and cardiovascular diseases, such as sudden death, acute pulmonary edema, insufficiency acute myocardial infarction (AMI) and stroke, accounting for 54% of deaths due to stroke and 47% of those due to ischemic heart disease.1

With the purpose of minimizing these complications in 2000, the Plan for Reorganization of Attention to Systemic Arterial Hypertension and Diabetes Mellitus was created by the Ministry of Health (MS), for which patients must be registered in the Hypertension Registration and Monitoring System And Diabetics (HIPERDIA). In this context, Basic Care, especially the Family Health Strategy (ESF), plays a central role in the implementation of integral care for patients with Systemic Hypertension (SAH).2

The development of actions to promote healthier lifestyles as strategies to prevent the onset of the disease, as well as its early detection, minimizing damages, disabilities, risks and expenses are fundamental in the care of hypertensive patients. The best alternative against the disease is to prevent the occurrence of these damages, improving the quality of life of the patients of the program and promoting the appropriate treatment of SAH.

Therefore, the importance of this issue is the fact that the frequency of health education activities in health services is reduced and individuals remain lacking additional information about their health status and what to do to minimize complications. In this context, the number of hospitalizations increases, many of which could be prevented through health education activities. The research is of relevance to society, as it will be demonstrating the importance of health education in the treatment of people with hypertension, consequently reducing the medical-social cost of Brazil and the health of the people affected.

Thus, the guiding question of this research is: How can health education favor the adherence to the treatment of patients with Systemic Arterial Hypertension (SAH) in the HIPERDIA program?

This study aimed to analyze the health education actions of patients with Systemic Arterial Hypertension in the HIPERDIA program developed in the waiting room of the Family Health Unit.

METHOD

This is a descriptive study with a qualitative approach, based on action research.3 Participants were 20 patients enrolled in the SAH service who attend the HIPERDIA program at USF Milton Rabelo monthly and who participated in the service consultations during the seven months in which the research was developed.

The inclusion criterion was the fact that the patient had the diagnosis of hypertension and was attending the HIPERDIA program on a monthly basis so, through the discussions in the waiting room, these patients could be changing their lifestyles and adhering to AH treatment.

The research was conducted at USF Milton Rabelo in the municipality of Jequié, in the waiting room of the HIPERDIA program. USF Milton Rabelo currently has two complete health teams that meet the recommendations of the Ministry of Health (MS) to monitor 600 to 1,000 families.4 The research was developed during the months of September to November of 2014 and, later, in the second moment of the research, in the months of January to April of 2015.

The data was produced in 28 meetings with the patients with a diagnosis of SAH in the HIPERDIA program, in the waiting room of the USF Milton Rabelo, in the municipality of Jequié. The meetings took place with four groups of hypertensive people that were attended monthly, totaling seven meetings in each group.

The same groups of preselected hypertensives were kept during the first month of care in the HIPERDIA program, and they participated in the semi-structured interview, in which the level of knowledge of the patients of the SAH program in the waiting rooms and other subsequent meetings. At the sixth meeting, the semi-structured interview was again carried out, applied at the first meeting with the patients with a diagnosis of hypertension to evaluate the level of knowledge acquired in the waiting room, concluding the data collection.

The research was carried out with the group of hypertensive people enrolled in the AH service of USF Milton Rabelo. There was an invitation for these registered patients, explaining the purpose of the research and only after their acceptance and the signing of the Informed Consent Term (TCLE), the interview was started. In the HIPERDIA
program, there were four groups attended during the month. Thus, the questionnaire was gradually applied during the research in all these groups, only for the participants who were assiduous to the program to have a better result in the research.

At the first moment, a semi-structured interview was applied to analyze the pre-existing knowledge by each research participant, and this interview had the following questions: What do you understand about high blood pressure? Do you know the name of the medicines you use daily? Do you know how to control high blood pressure? Besides medicines, what are the other ways of controlling high blood pressure? Do you know what the person with high blood pressure should not eat? Do you know what causes high blood pressure? Does high blood pressure have a cure? Do you know what happens to the individual who does not treat high blood pressure? Do you know if all patients with a diagnosis of SAH need to take medicine? Justify.

In the second moment of the research, health education activities were carried out, and the subjects applied were pre-selected by the researcher based on the main contents described by articles and books, regarding what a person with hypertension should know, having a better control of the pathology. In this way the following topics were selected: What is HAS; What causes HAS; Strategies to control hypertension; Medicines administered at home for the treatment of hypertension; Effect of drugs used to control systemic arterial hypertension in the body; Patient feeding with diagnosis of systemic arterial hypertension; Physical exercises that can be done in the activities of daily living.

During the moments in the waiting rooms with the themes described above, it was possible to evaluate the knowledge of each participant. Thus, we identified some modifiable and non-modifiable factors that contributed or not to the best research result. The non-modifiable factors identified were advanced age, hearing impairment and speech difficulties. The modifiable factor was illiteracy since about 95% of the participants did not have an education.

RESULTS AND DISCUSSION

The results show the characteristics of the participants of the HIRPERDIA groups, followed by a discussion.

Characteristics of participants in the HIPERDIA research program
In this study, 20 patients were enrolled, who were enrolled in the HIPERDIA program at the Family Health Unit - Milton Rabelo. From the analysis of the data, it was verified that 17 (85%) of the respondents were female because they play the role of caregivers for them and the family in society. However, only 3 (15%) were male.

All the participants were attending the monthly consultations, obeying the research criteria, and only the patients who participated in the survey participated in all the moments of the survey.

Regarding the age group, it was concentrated between 35 and 45 years old with 2 participants (10%), 5 participants were 45 and 55 years old (25%), 5 participants were 55 and 65 years old (25%) and 8 participants were over 65 years old (40%).

These results are convergent with the authors’ who demonstrate that women seek more for health services, increasing their chances of having the diagnosis of hypertension recognized earlier. Other similar studies, besides affirming that women having a higher survival rate than men, are more likely to suffer from chronic diseases. Another authors have justified this higher prevalence of the disease in women due to this group has an increase in risk factors with advancing age has been observed, although this increase does not represent a normal physiological behavior. Therefore, according to the same authors, prevention constitutes the most efficient means to combat hypertension, avoiding the difficulties and the high social cost of its treatment and its complications. However, other authors affirm that hypertension in the elderly deserves greater attention due to the vulnerability to the cardiovascular complications determined by hypertension, as well as other risk factors that accumulate with the time.

**Interview analysis**

The participants of the research were identified as U, corresponding to a participant and with the numbering from 1 to 20, since there were 20 participants in the research.

**Category 1: Patient’s knowledge of hypertension**

**Subcategory 1.1: Knowledge about HAS**

**1st moment: Previous knowledge**

According to the following statements, the knowledge about arterial hypertension of the research participants is observed.

- I do not know. (U2)
- I do not understand anything. (U7)
- I do not understand anything. (U15)

**3rd moment: Acquired knowledge**

In the speeches of the participants, there is the knowledge acquired after the health education activities in the waiting room, on arterial hypertension:

- [...] we can not eat salt, we can not eat fat, because if we facilitate we can have a stroke, it can be paralytic in bed, we must have rest, walk, to be able to have a few days to live. (U2)
- What I understand about high blood pressure is that when I'm sleepy and dizzy it gets high. (U3)
- [...] we can not eat anything salty, we can not eat oil, because it hurts health, we can not walk in the hot sun and walk by foot. (U7)
- [...] I understand as soon as there are hours that we have a headache, neck pain, your body is a little bad [...] and I see that my head is a little dizzy then I take the medicine to improve. (U15)

Regarding the patients’ speeches, the lack of knowledge about the HA disease was verified at the first moment of the research at USF Milton Rabelo.

In the second moment, a better understanding of the disease can be detected when the symptoms are stated and the food that can not be ingested. However, it is clear

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Table 1. Distribution of the characteristics of the HIPERDIA program participants in the research. Jequié, Bahia, 2015.
that even though we have some idea of what SAH is, patients need longer guidelines, especially about blood pressure levels, because the existing difficulties such as advanced age, stroke sequel, hearing impairment, among others, hindering to learn the subject matter explained during the sessions in the waiting rooms.

The results found in the research are convergent with other authors who report that there is a lack of understanding of the concepts of arterial hypertension by the patients, explaining their reduced interest in their health problem.\textsuperscript{13-14} It is important to note that some of the Hypertensive participants confused symptoms and concepts, requiring guidance, through health promotion. Thus, the importance offered by the professionals of the area is important to reduce this lack of knowledge.

\textbullet \textbf{Subcategory 1.2:} Knowledge of the patients on the measures of control of arterial hypertension.

\textbf{1st momento:} Previous knowledge

The following statements evidenced the prior knowledge of the participants about the measures of control of arterial hypertension.

\begin{itemize}
  \item I understand that we can not eat salty food, we can not eat oily food, we can not eat sweet thing, because of diabetes not to catch and that is. (U1)
  \item What I understand is drinking medicine and being healthy. (U5)
  \item With high blood pressure we have to go walking, do not eat fat, do not eat salt, what I know is that. (U10)
\end{itemize}

\textbf{3rd momento:} Acquired knowledge

The following statements confirm the knowledge acquired about the measures of control of hypertension.

\begin{itemize}
  \item [...] people can not eat salt, fats and have to go for a walk […], if we do the diet, it goes down. (U1)
  \item Health and medicine. (U5)
  \item I understand it is treacherous. (U10)
\end{itemize}

It was noticed that the consumption of salt and fats were the answers most cited by the hypertensives interviewed in the two moments of the research. Drug therapy was also mentioned in the two moments of the research. Therefore, the answers are convergent in the first and second moments.

Within this context, lifestyle changes such as reducing body weight and salt intake, reducing alcohol consumption, and regular physical exercise deserve special focus. These measures are not always well accepted, causing constraints and even resistance in adherence to treatment. However, the results are consistent with the authors\textsuperscript{15} who state that there are factors hindering hypertensive patients to adhere to changes in eating habits and lifestyles to contribute to the control of hypertension.

Inadequate and excessive intake of salt, overweight, obesity and sedentary lifestyle are powerful components that trigger the pathology, both acting as independent agents and acting together. Considering that they are interrelated circumstances, the probability of developing the disease increases considerably.\textsuperscript{16}

For this reason, the participants’ lifestyle should be considered. Some strategies, such as food re-education programs, monitoring of the nutritional menu within the health units and increase of physical activity are alternatives to reduce the high anthropometric indexes that have a direct correlation with hypertension.

\textbullet \textbf{Subcategory 1.3:} Understanding of patients on what is high blood pressure.

\textbf{1st moment:} Previous knowledge

The speeches below evidence the patients’ prior knowledge about what is high blood pressure.

\begin{itemize}
  \item I understand why we’re not up for it and it goes up, it goes up, when it’s normal, and when it’s high I get a headache (U13).
  \item High blood pressure is our heart, so if it goes down as mine is high I get bad, I get sick from the tremor, I get nervous, it does not make me hungry and it does not make me sleepy (U18).
  \item I understand that we can not eat salty food, fat and fry (U 19).
\end{itemize}

\textbf{3rd moment:} Acquired knowledge

The statements below check the knowledge gained from patients about what is high blood pressure.

\begin{itemize}
  \item That’s when I tighten my throat a lot and I get sick. (U13)
  \item [...] is that the person becomes nervous with lack of patience, gets a state of nerve […]. (U18)
  \item [...] we can not eat salt and not fat, can not eat beans […]. (E 19)
\end{itemize}

The patients’ knowledge about the meaning of hypertension is through the symptoms and what they can do to be able to control it, especially in relation to food, in both questions. Most of the participants incorrectly answered the meaning of AH, which was proven when asked what they meant by “high blood pressure”. Instead of defining SAH, they used the signs and symptoms of the disease as an explanation, both in previous knowledge and acquired knowledge.
The most food related to SAH is salt. In societies where salt is most consumed, the number of hypertensive people is higher. The intake of salt in the diet, by the patients besides being influenced by the financial condition, involves feelings of pleasure in the tasting of more temperate foods by them.17

Also, economic, psychosocial, stress, specific emotions contribute to the onset and maintenance of hypertension and may act as barriers to adherence to treatment and changes in habits.18

In this context, being aware of the signs and symptoms of the disease and seeking appropriate care is the most convenient alternative. However, most of the time, this does not happen. With this, the low adherence to the treatment, medicated or not, of systemic arterial hypertension is a reason for concern of professionals who work in primary care.

Subcategory 1.4: Patients’ knowledge about the drug treatment they use to control high blood pressure.

1st moment: Previous knowledge

The testimonials below discusses the previous knowledge of patients about the drug treatment they use to control high blood pressure.

No, because I can not read. I know which one I’ll take because the nurse gives me. (U1)
Captopril and hydrochlorothiazide. (U5)
I know but it’s a bit complicated to talk about it, I think it’s hydrochlorothiazide. (U6)
I know it’s Lozartan 50 mg. (U9)

3rd moment: Acquired knowledge

The following statements prove the patients’ previous knowledge about the drug treatment they use to control hypertension.

I do not know, I do not remember. (U1)
Captopril and hydrochlorothiazide. (U5)
No, it’s a very strange name. But I go with him in the bag. (U6)
I take that good little captopril. (U9)

Generally, by the statements explained above, patients are aware of the need to perform a drug treatment to control hypertension. There was no evolution regarding the answers when we compared the two knowledge (previous and acquired).

At both times, insecurity when reporting which type of medication they use and under what treatment they remain. This leads us to believe that the low level of knowledge of the importance of the treatment of hypertension can be justified by the lack of adequate guidance by the health professionals and the inclusion of strategies capable of clarifying doubts. Lack of education also explains this lack of knowledge. However, during the sessions held in the waiting rooms, patients who could not remember the name of the medication were advised to always be with the medicine in hand and in the patients’ response, there were 6 with a change of habit.

Some authors have pointed out that the main reasons that contribute to the patient abandoning the treatment are the high cost of medication, the need to take it several times a day, the occurrence of undesirable effects, the lack of knowledge of the complications, the absence of symptomatology, and forgetfulness.19 Added to these factors, when the awareness process is neglected, the incorrect use of the drug may occur and lead the patient to not follow medical prescriptions satisfactorily.

Faced with this reality, the health team that works directly with patients with SAH should be able to provide adequate guidance and assistance regarding the treatment of hypertension to avoid complications and abandonment of treatment.

Subcategory 1.5: Patients’ knowledge about eating habits to control hypertension

1st moment: Previous knowledge

The following statements are about the patient’s previous knowledge about eating habits for the control of hypertension

It is not to eat salt, fat […] (U2)
Do not eat fat, only eat vegetables […]. (U5)
[…] I do not eat a lot of salt, fried, fat, that I even liked a meat roast with that fat one more today I can not take more, soda can not either. (U9)
Do not eat salty thing is not eat too sweet and control it with food. (P14)

3rd moment: Acquired knowledge:

In the following speeches, the acquired knowledge about the eating habits to control hypertension is verified.

To control high blood pressure […], I can not eat salt, I can not eat fat […]. (U2)
The person does not eat fat, nor certain foods […]. (U4)
You can not eat fat and salty food. (U5)
I feed myself everything for high blood pressure. (U9)
[…] the person does not eat fry and fat. (U14)

In patients’ statements, it was noticed that a significant portion of the interviewees, after discovering that they were hypertensive, they adopted only drug therapy and reduced salt intake of strategies capable of clarifying doubts. Lack of education also explains this lack of knowledge. However, during the sessions held in the waiting rooms, patients who could not remember the name of the medication were advised to always be with the medicine in hand and in the patients’ response, there were 6 with a change of habit.
intake in meals as a form of treatment, and these responses are repeated in the acquired knowledge. This data suggests, once again, about continuing health education is of fundamental importance.

It is consistent to state that the clinical treatment of hypertension is based on drug therapy, as previously explained, and also on the adoption of new habits, such as regular physical exercise, in eliminating risk factors (such as smoking, abusive use of alcohol, physical inactivity, etc.) and especially in a healthy diet.

Committing to follow a treatment requires great efforts by the hypertensive person. This commitment includes changes in eating and living habits, control of weight control, reduction of alcohol consumption, smoking cessation, and regular physical activity practice.20-21,22-23

- Subcategory 1.6: Patient knowledge about the causes of high blood pressure.

1st moment: Previous knowledge

In the testimonials below, it is verified the previous knowledge of patients about the causes of hypertension.

[...] when we put a lot of salt in the food. (U1)
[...] it's too much stress and too much worry. (U2)
It's concern and I did not sleep properly. (U11)
[...] she does not feel well there she gets high blood pressure. (U12)
[...] because of the food, because it is full of medicine to grow like the chicken [...]. (U13)
[...] it is when the person becomes angry and the blood is weak. (U18)
[...] is nervous and eat plenty of salt. (U20)

3rd moment: Acquired knowledge

In the speeches below, it is verified the acquired knowledge about the causes of arterial hypertension.

Too much worry and not doing the right diet. (U1)
[...] it's a lot of strong stuff that we eat without limit and worry too. (U2)
[...] bad eating, and stress. (U11)
If you eat things wrong and do not overdo it. (U12)
[...] it is nervousness [...]. (U13)
Take anger, get too nervous, sometimes get it inside the heart without being able to talk, it goes ups. (U18)
I think, it's oil, salt and nervousness. (U20)

Based on the interviewees’ speeches, it is clear that none of the patients know the causes of the disease, leaving explicit ignorance about AH. It is important to make it clear and elucidate that causes are unrelated to symptoms of the disease or to factors that make blood pressure rise as reported by most of the respondents.

It is evident that the identification of the causes has been the concern of all who work with the hypertensive patient, reducing the quality of life of the patient and increasing the expenses with health resources. Thus, both the previous knowledge and acquired knowledge, the symptoms of the disease and factors that cause blood pressure to rise have been confused at all times with the causes of hypertension, a fact that needs to be urgently demystified.

The possible causes of primary hypertension are related to changes in the autonomic nervous system, renin-angiotensin-androsterone metabolism, renal sodium reabsorption and genetic variations. SAH may also be influenced by insulin resistance.24 Secondary causes of hypertension are related to pheochromocytoma, Cushing’s syndrome, hyperthyroidism and hypothyroidism, chronic renal disease, renovascular disorders, oral contraceptive use, coarctation of the aorta and primary aldosteronism, among others. Other genetic factors also interfere in the development of SAH.18

- Category 2: Pharmacological and non-pharmacological treatment

- Subcategory 2.1: Pharmacological treatment

1st moment: Previous knowledge

In the statements below, the patients’ previous knowledge about pharmacological treatment is verified.

I take the medicine [...]. (U8)
I take the enalapril remedy right. (U13)
I take the medicine at 4 o'clock in the morning [...]. (U17)
[...] take the medicine at the correct time. (U20)

3rd moment: Acquired knowledge

In the statements below, the patients’ previous knowledge about pharmacological treatment is checked.

I take the medicine at the right time, so as not to pass the time of the effect [...]. (U8)
[...] take the medicine at the right time. (U13)
[...] take medicine 3 times a day at the right time. (U17)
Taking medicine 1 in the morning and 2 at noon. (U20)

Regarding the pharmacological treatment, it was possible to verify by the participants’
statements that the previous knowledge about the drug treatment was not lost, when they were submitted to the acquired knowledge. This shows the importance that these patients are giving to the drugs that need to be taken for the control of hypertension and consequently adherence to treatment.

Above all, the patient’s stimulation becomes paramount to adopt healthy habits of life, such as maintaining adequate weight, regular physical activity, smoking cessation and alcoholism, as well as reducing sodium consumption and lipids in food.²⁵

Non adherence to drug therapy occurs when the patient’s behavior does not coincide with the health professional’s recommendations, establishing a significant challenge for the professionals who assist them. The problem of adherence to drug treatment is complex.

♦ Subcategory 2.2: Non-pharmacological treatment

1st moment: Previous knowledge

In the speeches below, it is verified the previous knowledge of the patients on the non-pharmacological treatment.

> It is to take lapa grass tea and lemon balm (U 4)
> [...] To have enough tea [...] (U7)
> Drinking holy grass tea and walnut nut and when I’m broke at home I drink tea too. (U12)
> [...] I drink tea [...] (U15)

3rd moment: Acquired knowledge

From time to time, I drink tea and lemon balm, as well as soothing chamomile, exercise and the right diet. (U 4)

I make passionfruit tea and other leaves that is good. (U7)

Do not eat fat, the rice has to be another, eat enough fish, chicken, which does not have too much fat, the meat has to be almost fat-free and can not eat fried meat, to be able to control it. (U12)

 [...] I do not eat too much salt, I do not drink too much coffee, I also do not drink too much coffee, I also do not eat too much fat [...] orange tea, basil, rosemary can control it. (U15)

It is noticed that there was a considerable advance in comparing the speeches of the interviewees of the previous knowledge with the acquired knowledge. Values and beliefs such as the use of teas were reported by the participants as a way to treat SAH, especially in previous knowledge. Consciousness in changing some habits such as physical activity practice and dietary changes had considerable consistency in the acquired knowledge, reinforcing once again the importance of continuous health education in this process of self-care.

Regarding lifestyle changes, such as practicing physical activities, the alcoholism, smoking, and overweight were not reported by any of the participants in the previous knowledge, showing that such practices are probably not adopted in the orientation of the professional according to the individual situation. Regarding non-medicated treatment, this main purpose is the changes in the patient’s lifestyle, aiming at reducing blood pressure.

♦ Category 3: Understanding the development of pathology

♦ Subcategory 3.1: Understanding the patient about the complications of arterial hypertension

1st moment: Previous knowledge

In the statements below, the patients’ previous knowledge about the complications of arterial hypertension is verified.

> It gives a heart attack and dies [...] (U1)
> [...] gives a stroke and dies. (U2)
> [...] she may die. (U8)
> I think it causes a stroke. (U16)

3rd moment: Acquired knowledge

It is the right death, he does not take care of himself and he does not have love nor to himself (U1)

It turns out that we get paralyzed in bed, have a stroke, then some walk, others do not walk anymore. (U2)

We pass away. (U8)

It causes a stroke and falls crippled on the bed [...]. (U16)

If AH is untreated, it can lead to serious cardiovascular and renal problems. Part of the interviewees showed knowledge explaining the complications brought about by the disease. However, it was not possible to follow advance of the previous knowledge to the acquired knowledge, since terms such as infarction, stroke and death were present in both, without any indication of clarification.

Before the testimonies, the illness is still characterized as an unknown world, because the patients had a minimum knowledge. Knowledge of the health condition and the means to improve it is fundamental for maintaining the quality of life. Therefore, it is up to the nurse to provide information sensitizing them to proper self-care and knowledge of cardiovascular complications, among others.²⁶

It can be seen that the most hypertensive patients do not have a more accurate and concrete perception of the harm that can result from hypertensive disease,
consequently interfering in the proposed treatment, refusal to adhere to it, as well as the alarming rates of cardiovascular complications and cerebrovascular. It is worth remembering here the role of health professionals in the continuous realization of health promotion, considering that the interviewees hardly assimilate all the information inherent in self-care. Since AH is a serious chronic condition that, if not treated correctly leads to the appearance of complications with compromised important organs, it is necessary specialized monitoring and education in continuous health.

It is up to health professionals, in particular the nurse, to implement an individualized plan of care, with clarification of doubts, giving guidelines, giving patients the opportunity to verbalize their life experiences, and how they take care of their own health. According to these authors, the changes in healthcare practices aimed at the construction of health promotion aim mainly to improve morbidity and mortality and decrease the negative repercussions of the life of the hypertensive patient.

**CONCLUSION**

Even after performing health education activities and conducting the interviews in the first and second moments of the action research, factors such as age, educational level, auditory and speech complications contribute to patients not absorb much of the content transmitted during the sessions in the waiting rooms on the topic.

An important fact to note in participants’ speeches, both in previous knowledge and acquired knowledge, is that they are aware that some habits can control their health condition, but that does not mean that these habits are practiced and correctly. Thus, the need for follow-up and integrated and educational assistance to clarify and guide these users about AH disease.

Faced with all this lack of health education, it is clear that the control of hypertension has become a challenge for health professionals, because the treatment requires the active participation of the hypertensive person to modify harmful habits of life and adopt others that benefit their hypertensive person to modify harmful habits.

The objectives of the study were answered, because it occurred to the intervention of the problem encountered, the observation of patient assiduity, the exchange of knowledge experiences, and all this was only possible because the methodology used was followed consistently and assiduously with the proposal, being sufficient for the conclusion of the research.

It can be concluded that health education is a very important strategy not only for the individual with a diagnosis of hypertension, but for any pathology that a professional may have diagnosed. It was noticed that this practice has been done only during the service, that way being not enough for the patient who knows on the topic. It is necessary to have a unique moment and a favorable environment so the patients can receive more attention and understand the content discussed, since only then they can health education overcome the problems encountered during this research.

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