



POPULAR EDUCATION IN HEALTH WITH THE GROUP HIPERDIA OF A BASIC HEALTH UNIT

EDUCAÇÃO POPULAR EM SAÚDE COM O GRUPO HIPERDIA DE UMA UNIDADE BÁSICA DE SAÚDE

EDUCACIÓN POPULAR EN SALUD CON EL GRUPO HIPERDIA DE UNA UNIDAD BÁSICA DE SANIDAD

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ABSTRACT

Objective: to discuss the practices of Popular Health Education with the Group HIPERDIA. **Method:** It is a descriptive and exploratory study with a qualitative approach, conducted with two nurses and 40 users registered in the HIPERDIA of a Basic Health Unit at the municipality of Mossoró/RN, Brazilian Northeast. The data were produced by means of systematic observation of nursing consultations and semi-structured interviews and analyzed using the thematic content analysis. The research was approved by the Research Ethics Committee (REC), under CAAE nº 0027.0.351.000-10. **Results:** the actions of health education are grounded on a model of vertical education, although they have elements that show desire for the introduction of the dialogic education. **Conclusion:** the Popular Education in Health assumes an important role in this context, since it is able to raise awareness of individuals about their rights and the possible benefits to their quality of life. **Descriptors:** Health Education; Nursing; Comprehensive Health Care.

RESUMO

Objetivo: discutir as práticas de Educação Popular em Saúde com o Grupo HIPERDIA. **Método:** estudo descritivo, exploratório, com abordagem qualitativa, realizado com duas enfermeiras e 40 usuários inscritos no HIPERDIA de uma Unidade Básica de Saúde no município de Mossoró/RN, Nordeste do Brasil. Os dados foram construídos pela observação sistemática das consultas de enfermagem e entrevistas semiestruturadas e analisados a partir da análise temática de conteúdo. A pesquisa foi aprovada pelo Comitê de Ética em Pesquisa (CEP), sob CAAE nº. 0027.0.351.000-10. **Resultados:** as ações de educação em saúde se encontram pautadas em uma educação verticalizada, embora apresentem elementos que mostram o anseio da introdução da educação dialógica. **Conclusão:** a Educação Popular em Saúde assume um papel importante nesse contexto, pois é capaz de instrumentalizar o indivíduo sobre seus direitos e os benefícios possíveis para sua qualidade de vida. **Descritores:** Educação em Saúde; Enfermagem; Assistência Integral à Saúde.

RESUMEN

Objetivo: discutir las prácticas de educación popular en sanidad con el grupo HIPERDIA. **Método:** estudio descriptivo, exploratorio con abordaje cualitativo, con dos enfermeras y 40 usuarios inscritos en el HIPERDIA de una Unidad Básica de Salud en el municipio de Mossoró (RN, Nordeste de Brasil). Los datos se construyeron a través de la observación sistemática de las consultas de enfermería y entrevistas semi-estructuradas, analizadas a partir del Análisis temático de contenido. La investigación fue aprobada por el Comité de Ética en Investigación, CAAE nº 0027.0.351.000-10. **Resultados:** las acciones de educación en salud se encuentran pautadas en una educación vertical, aunque presente elementos que muestran el ansia por introducir la educación de corte dialógico. **Conclusión:** la educación popular en salud asume un papel importante en este contexto, puesto que es capaz de instrumentalizar el individuo sobre sus derechos y los beneficios posibles para su calidad de vida. **Descriptores:** Educación en Salud; Enfermería; Asistencia Integral a la Salud.

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INTRODUCTION

In all practices developed in the scope of the Brazilian Unified Health System (SUS), health education is included, by representing an essential mechanism in the direct relationship between users and services, as well as in formulating health policies in a shared manner.¹ The principle of integrality of the SUS also makes reference to incorporation of knowledge, practices, experiences and spaces of care. For this purpose, it becomes necessary having dialogic educational practices focused on the realities of life of users, enabling the recovery of the history of life and, consequently, increasing the autonomy and co-responsibility of individuals about their health-disease process, thus pushing the health education towards to ideas to promote health.²⁻³

Health promotion is essential to ensure the integrality of health actions. In this context, the institutionalization of Popular Education in Health, as a continuous and participatory process, aims at training autonomous citizens with capacity to build and understand the health-disease-care processes themselves.⁴ Meanwhile, the Popular Education in Health presents itself as a means for transforming traditional education practices and health actions, making a bet on the “progressive enlargement of the critical analysis of reality on the part of collectivities in proportion as they are, through the exercise of popular participation, producers of their own history”.^{5:11}

Thus, popular education seeks to pedagogically work the human being and the groups involved in the process of popular participation, fostering collective forms of learning and investigation to promote the growth of the capacity for critical analysis of reality and improvement of coping and fighting strategies.⁶ Within this process of educational practices, the basic care, among the different environments of health services, is highlighted as a privileged context, given the fact that this environment has a working philosophy that provides the implementation of these actions.

In the Family Health Strategy (FHS), health education presents itself as a practice assigned to all professionals who comprise this team, in order to develop health-related educational processes aimed at improving care, working for improving the quality of life and, consequently, promoting the health of individuals.⁶ In this sense, FSH is considered as a favorable environment for the development of Popular Education in Health,

due to the fact that this is the main strategy to reorient the assistential model from the basic care. Hence, this is the place where one should develop actions of health education in priority way.⁷

In the FHS units, Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM) are worked through the HIPERDIA, which is a computerized system for registration and monitoring of hypertensive and diabetic people.⁸ This system enables the receipt of prescribed medications, can define the epidemiological profile of this population and, consequently, the development of strategies of public health that will lead to the modification of the current condition, the improvement of the quality of life of these people and the reduction of social costs.¹

It is important to know the building of knowledge of the population about the health field and how this knowledge can affect the quality of life of individuals and society. The interest in this topic was originated during the traineeships in some BHUs, where it was found a great amount of hypertensive and diabetic people in the area covered by the FHS and that, in most cases, this group does not have adequate information about its clinical condition and how to act for improving its quality of life. Then, we asked: how could we provide a Popular Education in Health with hypertensive and diabetic people in a UBS at the municipality of Mossoró/RN?

OBJECTIVE

- To discuss practices of Popular Education in Health (PEH) with the Group HIPERDIA.

METHOD

It is a paper elaborated from the Term Paper << Popular Education in Health with the HIPERDIA’s group of a BHU at the municipality of Mossoró >> presented to the Faculty of Nursing New Hope (FACENE), Mossoró/RN, Brazil, 2011.

It is a descriptive and exploratory study with a qualitative approach.⁹ For its conduction, we tried to understand the essence of phenomena that involve the proposed theme, contemplating the social relationships, the determinants and the ways through which they are organized in the society and explain it. This was performed in the BHU Doctor José Fernandes de Melo, which is located in the neighborhood of Lagoa do Mato, in Mossoró/RN. This unit has two teams of the FHS.

The study was comprised of nurses of the teams of the FHS working in the above

mentioned BHU, who have indirectly participated, through the observation of their consultations of HIPERDIA. This observation was conducted by the researcher. On the whole, we found 429 users of this service registered in the HIPERDIA. As to the sample, it was consisted of two nurses, representing 100% of the population, and 40 (9,3%) users registered in the HIPERDIA. The inclusion criteria were: to have performed at least one monthly consultation in the HIPERDIA in the past six months in the BHU and have cognitive condition to answer the interview.

To achieve the objective of the investigation, it was used an observation roadmap, through which the participant researcher observed how is the occurrence of process of health education during the nursing consultations with users registered in the HIPERDIA; and a structured roadmap of interview, addressing users, allowing the subjects to expose their knowledge, without answers or conditions pre-established by the researcher.

The data collection was conducted during the months of September and October 2010, according to the availability of nurses and users of the Program HIPERDIA. The observations of nursing consultations allowed us to obtain elements for producing possible answers to the research problem elaborated by the researchers.

The interviews were individually conducted in the sector of reception of the unit in question, before the nursing consultations. In the approach to users, it was noted that the fears, in most cases, were related of not knowing to answer the questions, but these fears were disappearing in the course of the conversation. The interviews were recorded by means of iPod. In order to ensure the reliability of data, the interviews were transcribed in their full version for getting a better understanding. The interview method allows us to maximize the seizure of the empirical reality, through a combination of objective and subjective questions.¹⁰

During the analysis of data, it was performed a comprehensive reading of the material transcribed from the interviews, followed by the approach of ideas, featuring the core of meaning and, finally, the interpretation, which was discussed in the light of the literature. We have used the thematic content analysis, being that it is a process that is essentially a qualifying operation that aims at reaching the core of understanding of the text. For this purpose, one should seek categories that are

meaningful words or expressions, under which the content of a speech will be organized.¹²

Next, one performs the classification and aggregation of data, selecting the theoretical or empirical categories responsible for the specification of the theme.¹² In order to preserve the identity of the participants of this research, when necessary to cite them during discussions, we will use the pseudonym Nurse 1 and Nurse 2 for participating nurses and Interviewed 1, Interviewed 2, Interviewed 3 and so on for users.

This study has considered the ethical principles of researches involving human beings. Therefore, it was developed respecting the ethical aspects established by the Resolution 196/96 of the National Health Council (CNS). It also involved elements about scientific production contained in the Resolution 311/2007 of the Federal Nursing Council (COFEN). To do that, the signature of the Free and Informed Consent Form (FICF) was a condition for participating in the survey. All this preceded the approval of the research project by the Ethics Committee of FACENE - FAMENE, under CAAE n° 0027.0.351.000-10.

RESULTS AND DISCUSSION

• Popular Education in Health in the HIPERDIA: a tool difficult to implement

In the studied reality, it is perceived that the time spent for the Program HIPERDIA is not enough to meet the demand of hypertensive patients, thus preventing the accomplishment of qualified consultations that act under the perspective of a comprehensive care, addressing a kind of health education that drive the individual to develop a critical thinking, when one needs to meet a very high amount of users.

One of the consequences of the aforementioned fact is the building, on the part of the population, of the mindset that consultations of HIPERDIA are intended only for the distribution of medications. When the consultation requires a longer time, it causes discomfort to those who are waiting. The consultation monthly held with the users with arterial hypertension through the Program HIPERDIA should not be limited to mere delivery of medications, transference of information and verification of blood pressure.²

It is noteworthy to highlight that the receipt of medications is just one strategy of this program for an integrated and qualitative care for this group. Realities like this hinder a humanized care, where there is the presence

of a qualified listening that allows the creation of bonds. This deficiency in care services contributes to the non-adherence from the patient towards the treatment, as it excludes its daily knowledge, which is so important to make it closer to the therapeutic conduct to be adopted. We have also observed that the educational activities are based on a reductionist understanding of the health-disease process, which distances the subject again from its social reality.²

Even with these problems, it was possible to observe, during consultations, the importance that nurses give to know the reality of their patients, asking about their habits, preferences and occupations and, from this, they find the guidelines relevant for each person. Thus, they realize the nurses as a supporting point, in which they can turn to when it is necessary.

[...] Only the fact that they come to our neighborhood, get communicating with us, what we should do and what we should not do, that's already a good guideline. (Interviewed 12)

I like the attendance service. After I'm taking the medications, I am feeling better. (Interviewed 15)

The nurse talks to me so much. I don't take the medicine rightly, then my diabetes was at 330 in last time, then she said: look! Lady, you should be aware. (Interviewed 11)

My blood pressure was also high, but it's because I live worried. She even asked me, so I said: not woman, that's because I live worried. (Interviewed 25)

Being aware of the need to know the reality in which the individual is inserted becomes one of the first steps to build a Popular Education in Health. Although this theme encompasses issues much more complex, to admit that the user has desires, feelings, experiences and preferences is crucial to work in caring in a suchway to share knowledge associating the treatment to the individual claims, especially when one discusses two chronic diseases such as SAH and DM, which require permanent changes in habits that are already crystallized in the lifestyle of the users.

• Vertical education and based on prescriptions of conducts

The methodology of dialogic education has as its starting point the systematic knowledge of the reality in which the subjects are living, which means to place individuals into their culture. They are encouraged to leave the silence to share their life experiences.¹³ Thus, it is important that the nursing professional, in the practice of health education, respects

the conceptions of life and of individual and collective health, thereby considering the way of living of people.¹⁴

Given the importance of the co-responsibility in the interaction with the population, during the observation period, it was possible to understand how the health education takes place during the nursing consultations with hypertensive and diabetic people. During the planning process of educational actions in health, the choice of appropriate methodologies is a phase of utmost importance for an autonomous consciousness on the part of users, since they are the foundation of the process and the point of intersection with the target audience. Therefore, this selection should be done according to the thematic at stake, characterization of the clientele, available resources, available time, among other factors.¹³

The building of methodological strategies of action, where the student is subjected to a situation that represents a problem experienced by its reality, becomes an important educational tool within the context of the users. The situations might be conducted during the elaboration of the presentation, where the dialogues and expressions are built, as well as during the representation itself. Thus, there is analysis and reflection about the situation, and several aspects, congruent and incongruent points and solutions of problems are found, among other issues.^{2:1050}

With respect to the two nurses, it was realized that there is interaction with the users, they [nurses] know their reality and they [users] feel safe to talk about health and personal life. To win the confidence of the subject with whom one wants to establish a dialogic relationship is paramount so that there is a Popular Education in Health, since it promotes open dialogue, allowing the subject to be opened for assimilating knowledge. Nonetheless, it is noteworthy to note that the vertical transmission persists in the practice of these nurses, who say how one should or should not proceed. Accordingly, health education is based on a prescriptive model, where the nursing professional recommends and the user follows. It is taught that the user is carrier of a disease and that needs to change its behaviors.

In the BHU, this reality occurs, perhaps because it is difficult to deal with Popular Education in Health when one has to live with the lack of involvement of other professionals in the FHS, as well as the high demand of users to be served. In the context of this

research, the educational activities of the nurses are not totally out of the cultural context of users, but are far from being a critical education.

The actions of health education will only have a real significance to users when they are raised from their knowledge, their needs, their interests, i.e., the social environment in which this individual is inserted. Thus, the actions will be built not only for the subjects, but together with the subjects, and thereby they will present a greater effectiveness.²

This reality was found in the speech of the interviewed individuals.

They teach us about foods. Asked a lot what we eat. We say that there is one thing or is another. Then, they say: that is like this, it should be so and so. Then, we got to follow what they say. (Interviewed 7)

They recommend a lot of diet, we sometimes don't follow it. Because we don't believe it, don't have faith. Because you know how it works. Some people even don't believe, but, because of it, we suffer the consequences. (Interviewed 10)

They teach us how to take the pills. Do you understand? They tell the foods that we should not eat. One spoonful of beans and another of rice; I didn't like that. (Interviewed 19)

They explain what diabetes is, you can do this, cannot do that, but it will really depend on the patient, following or not what they say. (Interviewed 22)

A person who is poor cannot have a food in the way it is supposed to be. I cannot eat pasta, but here and there I end up eating it. They should replace the pasta, but, for poor people, mass is cheaper than other foods. They say like this: eat fruit. As much as we eat fruit, we won't always afford to buy fruits. Eat a fruit and that's all, but we spend the day eating pasta. (Interviewed 27)

The nurse always explains about the manner to follow the way of feeding, for we don't do what is not right [...]. (Interviewed 33)

It is necessary that the patient knows more about its disease, in order to facilitate its treatment, making itself more active and autonomous. In this sense, the educational practices should be carried out from an educational model that provides an environment capable of stimulating the user to develop its criticality and transformative capacity so that it can understand all the subjects involved in the issue as stakeholders in the teaching-learning process, with sights to answer all the needs indicated by the subjective reality of each individual.¹⁴

• Conceptions of users about the disease

The conceptions of users about their diseases are related to the symptoms that they have, change in habits that they need to have, control of medications and, at last, some complications that these diseases can cause.

I was made aware that I'm hypertensive, because my blood pressure had changed much lately. And to control it, I'm taking medications. (Interviewed 1)

When I feel dizzy, have a headache, so I know that it is high. (Interviewed 4)

I know it comes from nervousness. I have to seek to stay calm. (Interviewed 9)

It can cause thrombosis. As to diabetic, the person can get blind. (Interviewed 13)

I know I take the medications; I take a lot of pills. (Interviewed 23)

Hypertension is caused by salty and oily foods. Generally, diabetic people tend to have high blood pressure. Diabetics are also prejudiced in its hearing, vision [...]. (Interviewed 31)

Before the speeches, one should perceive that the users have misconceptions about the disease, in addition to a very limited knowledge about the clinical picture, which hinders the adherence to the treatment. In this sense, the treatment for controlling SAH and DM includes the modification of lifestyle. This is one of the reasons for the lack of adherence to the treatment, because it demands change in the very idea of health that the individual possesses, which turns the change into something too complex, since the conception of health is formed through experience and personal knowledge of each individual, being that it is closely connected with his/her beliefs, ideas, values, thoughts and feelings.

The behavior change required to the achievement of completion of the comprehensive treatment of patients with arterial hypertension is linked to several socioeconomic and cultural factors that permeate the nurse-user relationship, including the theoretical and methodological foundations underpinning educational practices. Thus, it becomes relevant that professionals to perform actions that address the various aspects involved in the educational process.^{2:1050}

This essential change in lifestyle of the user living with SAH and DM is related to the processing of information as something relevant to his/her life, because processing and knowledge that emerge from the educational activities are interdependent. The more integrated is the general knowledge of the users, the higher their interest in the matters deemed as interesting, including

those related to their health-disease-care processes.¹⁵

As SAH and DM are diseases that can be asymptomatic, by presenting non-specific symptoms that might be attributed to other diseases or even when are the result of already installed complications, we have a factor that can hinder the adherence of the patient in relation to the treatment, if there is no educational action leading him/her to the integration with the therapeutic procedures, since it is difficult to change behaviors and habits, in addition to permanently relying on medications, when there are no symptoms and neither knowledge of the risk to which it is subjected.

I really didn't want to take medications. I didn't want to admit it, you know what I mean? I didn't want to be hypertensive, because it was so sudden, I had no problem, it was always normal. (Interviewed 15)

With the vision of the educational process in a liberating trend, the nursing professional encourages the act of talking by making the individual to interfere, dialog and feel capable. Only the dialog generates a critical thinking that is also capable of generating dialog. The basic premise of those who carry out the educational process within this perspective should be to foster the personal empowerment of the human beings with whom they interact.¹⁶

The important thing is to help the human being to help himself/herself, turning him/her into a recovery agent with a critical and reflective stance of his/her problems. The objective of the dialogic education is not to inform about health, but rather to transform existing skills/knowledge. To perform the dialogic education in health, one needs a favorable environment, it requires time so that one can understand the needs of the subject and, subsequently, together, people can formulate ideas for being used throughout the treatment.

Education is not just to conduct a dialogue with each other, but rather to build a deeply dialogic thought. Unfortunately, the inflexible organization itself of the care service prevents a position for the comprehensive action of professionals who, in spite of recognizing the need for Popular Education in Health, are stuck to the routine established by the institution and cannot implement the FHS in an actual manner, which advocates qualifying assistance and ensures health promotion.¹⁶

Monthly meetings, in addition to being a time of socialization and offering educational practices to this group, provide the

integration of users by facilitating the adherence in relation to their treatment.

CONCLUSION

The current health context requires a more integral care, which emphasizes health promotion, not only related to risk factors, but to all the determinants of quality of life of people. In this context, the Popular Education in Health (PEH) assumes an important role, as it stimulates the individual to fight and seek possible progress to improve its health status and also increase its quality of life. Therefore, the incorporation of this practice in the care of individuals with hypertension and diabetes is essential, because these are chronic diseases, which have determining social factors and because such pathologies require permanent changes in habits, as shown in the survey. Nevertheless, when there is a full assistance where the PEH is inserted, this problem tends to disappear as people develop practices of transformation of skills from the perception of reality that the individual and the collective already have.

The nursing professionals should not impose their knowledge, because these given guidelines cannot be adopted due to their incompatibility with the reality. To know the learning-related needs of hypertensive and diabetic people is to consider the importance of these subjects in determining their own self-care. Behavioral changes as significant as those expected from hypertensive and diabetic patients should not be imposed and only can be performed over time, with the understanding of the need for change. To raise awareness of these people to understand this need for personal changes in lifestyle is the key role of professionals involved in the treatment of this group.

This research, although has demonstrated that the PEH is not performed in nursing care shares of the BHU under study, important step towards implementing this educational practice, is data as nurses (educators) value the territory of insertion of the subject, ensuring trust and support, as well the desire to change the current reality, planning projects to improve care and thereby enabling the building of the PEH. In addition to the expansion of knowledge about the PEH and the complexity that involves discussions regarding this practice, especially when it is linked to diseases such as hypertension and diabetes, this research has contributed for that the users might reflect on their lives and on their health conditions, as well as made possible an opportunity to assess the services by the users themselves. Moreover, it has

enabling an understanding of the conceptions of this group about the theme at stake. In short, it becomes important that the Nursing works under this perspective of a care in which there is health promotion with the incorporation of the Popular Education in Health so that one can provide a comprehensive care aimed at reaching the quality of life of the individual and of the collectivity.

We believe that, for achieving a more effective participation of the user in its treatment, it becomes necessary to have practices to turn him/her into an agent of his/her therapeutic treatment, leaving him/her conscious of the need to interact so that he/she can achieve control of the disease.

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