RESIGNIFICATION OF CARE FOR PERSONS WITH SYSTEMIC ARTERIAL HYPERTENSION

RESIGNIFICACIÓN DEL CUIDADO A LAS PERSONAS CON HIPERTENSIÓN ARTERIAL SISTÉMICA

ABSTRACT

Objective: to analyze the resignification of the care provided by a Family Health Strategy team to people with systemic arterial hypertension from the historical-cultural perspective. Method: this is a qualitative study conducted in a Family Health Strategy unit divided into five phases and based on the planning of actions in health services and with a historical-cultural approach, through the technique of focal group and the operative group. Results: data obtained in the focal and operative groups were organized according to the researcher and the team as mediators in the interactions and meanings attributed to the care model. Conclusion: the Family Health Strategy team was able to resignify the care given to people with systemic arterial hypertension allowing the re-elaboration of the care model.

RESUMEN

Objetivo: analizar la ressignificación del cuidado prestado por un equipo de la Estrategia de Salud de la Familia a las personas con hipertensión arterial sistémica en la perspectiva histórico-cultural. Método: estudio cualitativo en una Estrategia de Salud de la Familia, dividido en cinco fases, con base en el planeamiento de acciones en servicios de salud y en abordaje histórico-cultural, por medio de la técnica de grupo focal y de grupo operativo. Resultados: los datos obtenidos en los grupos focal y operativo organizaronse en temas de acuerdo con los principios de Vygotsky: Estrategia de Salud de la Familia: espacio vivo para la relación dialógica; O papel del pesquisador e da equipe como mediadores nas interações e Significados atribuídos ao modelo assistencial. Conclusión: a equipe da Estratégia de Saúde da Família conseguiu ressignificar o cuidado prestado às pessoas com hipertensão arterial sistémica, o que permitiu a reelaboração do modelo assistencial.

RESUMEN

Objetivo: analizar la re-significación del cuidado prestado por un equipo de la Estrategia de Salud de la Familia a las personas con hipertensión arterial sistémica en la perspectiva histórico-cultural. Método: estudio cualitativo en una Estrategia de Salud de la Familia, dividido en cinco fases, con base en el planeamiento de acciones en servicios de salud y en enfoque histórico-cultural, por medio de la técnica de grupo focal y del grupo operativo. Resultados: los datos obtenidos en los grupos focal y operativo se organizaron en temas de acuerdo con los principios de Vygotsky: Estrategia de Salud de la Familia: espacio vivo para la relación dialógica; El papel del investigador y del equipo como mediadores en las interacciones y Significados atribuídos al modelo asistencial. Conclusión: el equipo de la Estrategia de Salud de la Familia consiguió dar re-significado al cuidado prestado a las personas con hipertensión arterial sistémica, lo que permitió la reelaboración del modelo asistencial.
The teams that operate in Family Health Strategy units face a great number of difficulties, and among these, the care for people with systemic arterial hypertension (SAH). In the care for SAH patients, it is important that the FHS team participates in processes of knowledge construction, assimilating and using both technological and humanistic innovations in a balanced way so that conditions to develop self-care in may be offered to these people in a more appropriate form, according to their socio-cultural context.

This conception is in agreement with the FHS guidelines. The central place of the patient and the search for a culturally contextualized practice require the FHS team to develop cultural competence, the ability to transcend a view focused only on the disease which characterizes a care model based on the principles of the Unified Health System, such as the universality of access, comprehensiveness, popular participation and equity.

It is therefore imperative to understand the meaning of care with a view to contributing to changes that make it possible to replace the model based on disease and spontaneous demand with a view for a Comprehensive Health Care Model, where there is a progressive incorporation of health promotion actions and prevention of risk of complications.

Thus, it is necessary to make use of theories to support the work process in the health field. It was decided to analyze the praxis of a FHS team in the planning of actions aimed at promoting the health of SAH patients, according to the historical-cultural approach of Lev Vigotski.

The historical-cultural approach of Vygotsky focuses on the search for new ways of understanding the human mind, from the historical-social context, aiming to trigger a process of change. This change is possible because in the interaction between two elements the synthesis is not the sum or juxtaposition of the two, but consists in the construction of something original and novel, in a process of transformation that generates new phenomena. Vygotsky's principles contribute to the health field by privileging the interaction and dialogical relationship between professionals and clients, corroborating the construction of new ways of thinking and acting in health services.

The scientific literature reiterates the need for studies to understand and intervene in primary health care in order to promote a change in the health care model. In this perspective, health education actions become an important ally to strengthen a systemic and proactive care that values subjective issues aimed at the construction of autonomy and responsibility of people in their own health care, and that of the whole community through knowledge transformation.

However, despite the growing interest of research to understand the cultural construction of the health/disease process and successful practices in the health sector, there is still a need for innovative studies that can effectively promote a change in the care provided by FHS teams, aiming at progressing and breaking up with the medicalization paradigm.

It should be emphasized that the resignification of care will prompt the improvement and development of increasingly creative and effective actions in the control of SAH. Such changes make it possible to replace a logic operated by processes of medicalization of existence and of individual and collective life with a logic based on the reception through listening and dialogue, establishing a commitment and a bond that stimulates more integrated practices, marked by intersectoriality and interdisciplinarity.

**OBJECTIVE**

- To analyze the resignification of the care performed by a FHS team to SAH patients from the historical-cultural perspective.

**METHOD**

This is a qualitative study carried out with a FHS team in the South of the state of Minas Gerais, Brazil. The FHS unit consists of seven attached micro-sectors divided by streets, according to their proximity. All FHS team members who work in the FHS unit and provide care for people with SAH were...
elected to participate in the study; this was the inclusion criterion.

The FHS team consists of 14 people: a nurse, a dentist, a nutritionist, a social worker, a speech therapist, a physical therapist, six community health workers, a nursing technician and a pharmacy assistant.

Data collection was carried out from March to April 2015, starting with the characterization of the participants through a script previously prepared by the researchers covering information such as age, sex, schooling, role in the team, marital status and religious belief.

The research was divided into five phases. The first phase aimed to raise the problems related to the care that the team has offered to SAH patients. The second phase aimed to prioritize these problems, as well as their definition. In the third, the objective was to describe and explain the problems and select the critical nodes. In the fourth phase, the design of the operations and the identification of critical resources were carried out. Finally, in the fifth phase, the analysis of feasibility, preparation and management of the plan were carried out. Each phase followed the framework proposed by Campos et al.11

For data collection, the focal group technique was used in the first phase; this technique has been used in several studies.12-13 In the subsequent phases, the operating group14 was recorded by means of a digital recorder. The focus group is a research technique that allows qualitative data to be obtained through group sessions in which six to 15 people share common characteristics and discuss various aspects of a specific theme.14 The objective is to develop ideas, obtain insights, understanding different perspectives and inquiries in an open and learning-rich environment.14 In the focus group, the following guiding question was used as a trigger: “How has the unit offered care to people with systemic arterial hypertension?”

The working group technique was drawn up in the 1940s by Argentine psychiatrist and psychoanalyst Pichon-Riviére who defined the group as a set of people, linked in time and space, articulated by their mutual internal representation who explicitly or implicitly proposed to a task, interacting in a network of roles with the establishment of links between them. The group represents a network of relationships based on the links between each component, and the whole group with interpersonal links between the participants.14

After each meeting, the researchers and the silent observer met to analyze the work performed. The silent observer is a fundamental figure in the Pichonian framework, as it is a record not only of the speeches of the participants but also the group vectors, body expressions and other information that allow the analysis of the group movement.14

There were two movements of analysis: one occurred throughout the operating groups, following the ten steps of planning and evaluating health actions11 were presented and discussed among the participants. The second movement took place after the end of the work with the team, through the content analysis of the transcriptions of the speeches, based on the historical-cultural approach3. The first movement resulted in proposals and implementation of group actions, developed by the members of the team, such as “Healthy chat”, “Healthy eating”, “Smoking combat group,” and “Physical activity group.” The second movement is the focus of this article. Figure 1 shows the summary of the methodological procedures adopted in the collection, organization and analysis of the data.
<table>
<thead>
<tr>
<th>Phase</th>
<th>Participants</th>
<th>Technique employed</th>
<th>Instruments/resources</th>
<th>Steps of the action plan (Campos, 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12 people - Nurse, Social worker, Dentist, Nutritionist, Speech therapist, CHAs (Community Health Agents), Nursing technician, Pharmacy assistant</td>
<td>Focus group</td>
<td>Digital recorder, list of topics to guide discussions</td>
<td>1 - Definition of the problems: it helps producing information that allows knowing the causes and consequences of the problem, that is, the situational diagnosis that consists of understanding the process that causes a problem.</td>
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<td>2 - Prioritization of problems: it consists in the selection of the main problems to be solved, considering their importance, urgency, and the coping capacity of the team.</td>
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<tr>
<td>2</td>
<td>13 people - Nurse, Social worker, Dentist, Nutritionist, Speech therapist, CHAs, Nursing technician, Pharmacy assistant</td>
<td>Operating group</td>
<td>Digital recorder, poster describing the problems encountered in the focus group</td>
<td>3 - Description of the problems: it consists in the understanding or explanation of each problem, that is, to characterize and describe them better.</td>
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<tr>
<td>3</td>
<td>14 people - Nurse, Physiotherapist, Social worker, Dentist, Nutritionist, Speech therapist, CHAs, Nursing technician, Pharmacy assistant</td>
<td>Operating group</td>
<td>Digital recorder, poster with the list of priority problems, with explanation and description of these problems</td>
<td>4 - Explanation of the problems: it aims to understand the genesis of the problem that we want to face based the identification of its causes.</td>
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<tr>
<td>4</td>
<td>14 people - Nurse, Physiotherapist, Social worker, Dentist, Nutritionist, Speech therapist, CHAs, Nursing technician, Pharmacy assistant</td>
<td>Operating group</td>
<td>Digital recorder, poster with operation plan and identification of critical resources</td>
<td>5 - Selection of critical nodes: it represents a type of cause of a problem that when faced is able to impact the main problem and effectively transform it.</td>
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<tr>
<td>5</td>
<td>6 people - Nurse, Social Worker, Dentist, Nutritionist, Speech therapist, CHAs, Nursing technician, Pharmacy assistant</td>
<td>Operating group</td>
<td>Digital recorder, Desktop and notebook projector</td>
<td>6 - Design of the operations: it can be synthesized by means of the following steps: description of the operations for the solution of the causes selected as “critical nodes”; identification of products and results for each elaborated operation; necessary resources for the development of operations.</td>
</tr>
<tr>
<td>6</td>
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<td>7 - Identification of critical resources: consists in the identification of the materials indispensable for the execution of an operation.</td>
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<td>7</td>
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<td>8 - Analysis of feasibility of the plan: it can be understood by the following steps: identification of the actors that control the critical resources used to implement each operation; analysis of the motivation of these actors in relation to the objectives to be achieved by the plan; and design of strategic actions to motivate the actors and develop the viability of the operation.</td>
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<td>8</td>
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<td>9 - Preparation of the operational plan: the main purpose of this step is to assign people responsible for the strategic projects and operations, as well as establish the deadlines for compliance with the actions that will be implemented.</td>
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<td>9</td>
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<td></td>
<td>10 - Management plan: it basically consists of designing a management model of the plan of action and discussing and defining the process of monitoring the plan and other instruments.</td>
</tr>
</tbody>
</table>

Figure 1. Summary of the methodological procedures adopted in the collection, organization and analysis of the data. Alfenas (MG), Brazil, 2015. Source: authors
This study was approved by the Research Ethics Committee of the Federal University of Alfenas under the CAEE: 41227215.2.0000.5142. The participants were asked to agree through the Informed Consent Form, and were informed on the guarantee of anonymity and right of withdrawal at any stage of the research. Participants were identified by fictitious names in order to preserve their anonymity.

RESULTS

Regarding the characterization, 14 participants were females, aged between 27 and 54 years. Six participants had higher education and eight had completed high school. Eleven reported being Catholic, one evangelical and two answered that they believe in God; seven were married, five were single, one was divorced and one was common-law married. There were six community workers, one nursing technician, one pharmacy assistant, one nurse, one dentist, one speech therapist, one nutritionist, one physical therapist and one social worker.

After reading the data obtained in the FG and in the operative group, the themes were organized according to the following Vigotski principles: dialogicity, mediation, interaction, meaning, learning, development and transformation. These results allowed an analysis on the transformative action and the resignification of care to people with SAH in the team, as well as the contribution of the historical-cultural approach to the health field.

♦ Family Health Strategy: living space for a dialogical relationship

The participants emphasized the importance of dialogicity as transformative action, which is evident in the following speech:

"The space for dialogue […] we are already doing here, it may remain. (Vanessa - Social worker)

[…] but I think it's important that we do it [meeting]; there used to be a proper day to meet, you know, just as before, you remember […]. (Daniela - Nurse)"

The resumption of the meetings mentioned by Daniela, as in other lines, highlights the importance of a space for dialogue, as well as of the team for the concretization, for the qualification and effectiveness of the care provided, which should be offered in a comprehensive manner:

"In the other management, it was mandatory to have that day […] on Thursday afternoon, it was meeting in all units, in all FHS units. (Paula - Health Agent)"

We were supposed to have a meeting, and it was very important because sometimes there is a problem that the team is not aware of, and there is always an idea. (Cátia - Dentist)

The speeches also indicated a certain disappointment with the current moment permeated by a context of instability, discouragement, demotivation, and lack of integration of the team, generating a feeling of devaluation and dissatisfaction. This was attributed to the change in health management with the resignation of the majority of workers due to the need to open a public tender.

The relevance of dialogicity does not apply only among members of the team; people with SAH also need to find in the team a space to present their problems and their anguishes, as it was observed in the following speech:

"Exactly, it is that person comes and tells that story of the maritaca that is doing art […] he [the physician] gives attention, he is very humble… he embraces the person. (Paula - Health Agent)

Qualified listening and a dialogical relationship between health professionals and people with hypertension allow the construction of autonomy and responsibility for care and self-care with health through knowledge transformation.

♦ The role of the researcher and the team as mediators in the interactions

We observed the relevance of the researcher as mediator in the process of resignification of care, being receptive, showing concern and involvement with the work process of the team, as demonstrated in the following speech:

"We'll start this conversation, this chat, something very informal, something to really know one another, and I would like to start this conversation with a question […] how has the care that the team has offered felt by people with systemic arterial hypertension? (Researcher)"

After the question, there was a deep silence and apprehension among the members of the team. However, one participant, who stood with his arms crossed, began to speak in a timid manner, but he gradually exposed his point of view and gave suggestions clearly and fluently. It was noticed that his speech acted as a trigger for the other members of the group.

♦ Meanings attributed to the care model

Regarding the meaning of the care model for the reorganization of the SUS and the Family Health Program, the data pointed to the biomedical model because for the
participants, this model is able to meet the needs of the people.

[...] the secretary of the health department could help by putting a gynecologist here, wow! It would be a dream come true. Because I would have more time available to attend to more people from the FHS [...] (Cíntia - health agent).

A gynecologist, they will not send a gynecologist because their intention is to send away the pediatrician [...] because they [managers] think [...] that it is not the directive of the FHS [...]. (Daniela - nurse)

Is that the physicians solves everything here, do you understand? [...] There is no specialist within the FHS [...] they [managers] are considering sending away even the pediatrician; they have not yet sent him away so far [...]. (Daniela - nurse)

Even the issue of referral to specialties, they insist with us to reduce, because they have to solve here without using another method [...]. (Jeane - nursing technique)

On the other hand, there are those who understand that the care model is related to health promotion and prevention. However, there is a difficulty in its implementation in the work process, considering that the technical care model still permeates the conception of people who seek care.

Primary care works with prevention and guidance, not with individual consultations, and it is usually provided to the group and collectively. We gather them, there is a hypertension group in another FHS already formed [...] but they [users] want treatment right away, do you understand? It is difficult for us to work in groups, they [the users] do not accept [...] (Greice - nutritionist)

That comes a bit from the culture. (Vanessa - social worker)

Despite this difficulty, the participants reiterated the importance of the implementation of collective actions and health promotion in detriment of the healing model.

They also pointed out that change of conception also among people who seek care, which points to the resignification of the concept of care.

Prevention is important, health maintenance [...] for nine years I’ve been working at the FHS, I see that there has been an improvement, more people have adhered, but very slowly. (Cátia - dentist)

In this sense, care has been a process built in a gradual and collective way, observed not only in the discussions of the operative group but also, and above all, in the proposals of health actions that have been gradually incorporated into the work process.

In this way care is no longer seen as a disease-centered model, but rather a model centered in the person and in the bonding.

I think the most important of all [...] in this waiting room [one of the actions proposed and executed by the operating group] is not clarifying things; it is creating the bond with the population because it is at that moment that the bond is created, especially in the case of the professionals of the unit. For example, sometimes I’m without a patient, and I go up to the room [waiting room], and have a little chat with them [...]. (Cátia - dentist)

Cátia’s speech reveals that the health actions carried out in the waiting room are privileged spaces for establishing bonding and embracement, reflecting the resignification of the team's work and the changes that have taken place in the assistance provided to the population with SAH.

**DISCUSSION**

With the objective of analyzing the resignification of the care by a FHS team to the people with SAH from the historical-cultural perspective, we verified that the FHS constitutes a living space that facilitates the dialogue, the opportunity of the people to share their problems, anguishes and for them to find support in health professionals because listening and embracement permeates the work process. Vygotsky built up an original conception of psychology and development of higher psychological processes that support current theories in various countries. In this conception, dialogue brings together the interlocutors of the subject, allowing in turn a series of abbreviations in spoken language and, in certain situations, creating purely predicative judgments. A dialogue presupposes the visual perception of the interlocutor, his mime and gestures, as well as the acoustic perception of the whole intonation of the speech. It is through language that men effectively concretize dialogue. Plans are elaborated through dialogue and conversation, jointly, for each family, defining more clearly the work of each professional in relation to the case. When workers gather to talk, we can more intensely visualize group processes that can act as a coping tool to overcoming stereotypes, conflicts and emerging problems.

We observed that the process mediated by language triggers the internalization of the constructed, as well as its exteriorization, through words, actions and behavior changes. The team should give attention, listen,
understand the actions of the other in order to organize the actions that must be taken to provide care for SAH patients.

On the basis of Vygotsky’s principles, it has also been shown that, as activities progress, social interactions widen, so that dialogue and participation happen spontaneously. The members of the team begin to interact with the researchers and reflections become present in each member of the group, in the search for a solution to the issues raised. The meetings were unique moments to turn some noise (problems) public, with respect to the work process among team members, and problems that generated dissatisfaction and conflict.

Vygotsky 3 treats this concept of mediation in the human-environment interaction through the use of instruments and signs. The systems of signs (language, writing, the number system), as well as the instruments, arise in societies throughout the course of human history and they change the social form and level of their cultural development. Vygotsky believed that the internalization of culturally produced sign systems causes behavioral transformations and establishes a link between the early and late forms of individual development.18 Thus the interaction made possible by language is what enables social advancement, which applies to the best organization of the actions that must be performed by the team in the care of people with SAH.

The interaction mediated by the other, researcher and team were fundamental for the resignification of care among health workers because it provoked the need to rethink the principles of FHS team and its performance among people with SAH. It is evident in Greice’s speech the ideological incorporation of the principles of the health reform and the Ottawa Charter for Health Promotion which is a letter of intent that seeks to contribute to health policies in all countries in an equitable and universal way.19 Greice also mentions the difficulty in implementing this model because the population itself does not understand the principles proposed by the health reform. Vanessa seeks a justification for the difficulty of implementing the care model to the cultural dimension of the people assisted at the FHS. The care model should not be understood only as the organizational and technical design of the services, but includes the way in which care actions are produced.9

Based on this understanding, it was noticed that the interaction with others allowed the participants to re-elaborate meanings for the care actions and, with this, the resignification of care.

The meaning and sense of the actions carried out by the workers are revealed through the word, that is, the awareness that the man presents in relation to the actions he performs is shown by means of what such actions represent for him, as this awareness comprises the modifications that this word articulates in his life. All this has a reflex in his objective relations, in the performance of this activity, or even in the meaning of this activity, something that happens in his life.20

In the present study, we perceived that the conception of care was based on the predominance of a fragmented system, characterized by the hierarchical organization; lack of continuity of health care and the focus on specialized services; the relative emphasis on curative and rehabilitative interventions; and a focus on professionals, especially physicians.21,9

In this sense, the study emphasizes that the SUS allows a new meaning to health as a social good, with primacy in health promotion actions and community-collective intervention.22 In this area, it could be seen that the FHS workers, after discussions and reflections, were able to glimpse the real meaning of the FHS with emancipatory and transformative actions in the social sense in order to overcome the obstacles imposed by the hegemonic model, with merely curative actions and grounded on the biomedical model.

During the meetings, it was possible to re-elaborate the meaning of care among health workers, from disease-centered care to person-centered care, with a proposal for actions that favor dialogical conversations.

It was found that the meetings were fundamental to motivate workers to find in their creativity and potential the capacity to make the work process more participatory and reflexive, with possibilities to meet the needs of people with SAH.

CONCLUSION

This research, developed on the historical-cultural approach, allowed us to analyze the collective construction of a strategic planning and the interpersonal relationship of the family health strategy team as transformative action and also the resignification of the care provided by this team to SAH patients.

The worldview focused on disease and medical consultations has been gradually replaced by a view based on prevention and health promotion, with proposals and implementation of group actions, developed
by team members, such as “Healthy Chat”, “Healthy Eating”, “Combat Smoking Group” and “Physical Activity Group”. These actions may contribute to lifestyle changes among people with systemic arterial hypertension.

The use of the operative group stimulated the critical vision and allowed the development of teaching-learning processes that valued the reflection on the proposed situations, triggering the search for solutions to the problems.

REFERENCES


Resignification of care for persons with...