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CASE REPORT ARTICLE

DIALOGUING ON THE UNIFIED HEALTH SYSTEM WITH THE COMMUNITY: AN EXPERIENCE REPORT IN THE CONTEXT OF HEALTH EDUCATION

DIALOGANDO SOBRE O SISTEMA ÚNICO DE SAÚDE COM A COMUNIDADE: UM RELATO DE EXPERIÊNCIA NO CONTEXTO DA EDUCAÇÃO EM SAÚDE DIALOGANDO SOBRE EL SISTEMA ÚNICO DE SALUD CON LA COMUNIDAD: UN RELATO DE EXPERIENCIA EN EL CONTEXTO DE LA EDUCACIÓN EN SALUD

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ABSTRACT

Objective: to inform the principles, the relevance and workability of the Family Health Unit (FHU). **Method:** this is a descriptive study, an experience report, experienced by nursing students, after implementation of the intervention project “Knowing the FHU and its actions”, which had the participation of 15 members of the community and the staff of a FHU attached to the municipality of Santo Antonio de Jesus/BA, situated in the Brazilian Northeast. **Results:** receptivity of the group to broaden its knowledge with regard to the importance of the proposed activity and the accomplishment of health education in the community. **Conclusion:** the completion of the activity provided a closer approximation of the health team of the FHU with the local community, thereby allowing the identification of the prior knowledge of the participants and demonstrating that the FHU is the beginning of the network that covers the entire context of health care. **Descriptors:** Health System; health education; Nursing.

RESUMO

Objetivo: informar os princípios, a relevância e a funcionalidade da Unidade de Saúde da Família (USF). **Método:** estudo descritivo, tipo relato de experiência, vivenciado por estudantes de enfermagem, após a execução do projeto de intervenção “Conhecendo a USF e suas ações”, o qual contou com a participação 15 pessoas da comunidade e a equipe de uma USF adstrita do município de Santo Antônio de Jesus/ BA, Nordeste do Brasil. **Resultados:** receptividade do grupo em ampliar os seus conhecimentos quanto à importância da atividade proposta e da realização da educação em saúde na comunidade. **Conclusão:** a realização da atividade proporcionou uma maior aproximação da equipe de saúde da USF com a comunidade local, permitindo a identificação do conhecimento prévio dos participantes, demonstrando que a USF é o início da rede que abrange toda a assistência à saúde. **Descritores:** Sistema Único de Saúde; Educação em Saúde; Enfermagem.

RESUMEN

Objetivo: informar acerca de los principios, la pertinencia y la funcionalidad de la Unidad de la Salud de la Familia (USF). **Método:** se trata de un estudio descriptivo, un relato de experiencia, experimentado por los estudiantes de enfermería, después de la implementación del proyecto de intervención “Conociendo la USF y sus acciones”, el cual contó con la participación de 15 miembros de la comunidad y el equipo de una USF vinculada al municipio de Santo Antonio de Jesus/BA, situada en el Nordeste de Brasil. **Resultados:** la receptividad del grupo para ampliar sus conocimientos en cuanto a la importancia de la actividad propuesta y de la realización de educación en salud en la comunidad. **Conclusión:** la realización de la actividad ha propiciado una mayor aproximación del equipo de salud de la USF con la comunidad local, lo que permite la identificación del conocimiento previo de los participantes, demostrando que la USF es el inicio de la red que abarca todas las acciones de atención de la salud. **Descriptores:** Sistema Único de Salud; Educación en Salud; Enfermería.

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INTRODUCTION

The Brazilian Unified Health System (SUS) was established by the Federal Constitution of 1988, in which is advocated, in its Article 196, that “health is a right of all citizens and a duty of the State”, and this right was regulated in 1990 by the Laws nº 8.080/90 and nº 8.142/90, which are considered as juridical and legal bases of the SUS.¹ The conquest of the right to health in our country took place through a collective social mobilization, from claims that gave rise to the movement known as “Sanitary Movement”, culminating in the accomplishment of the 8th National Health Conference, in 1986, whose resolutions were the basis for insertion of the Health Law in the Federal Constitution of 1988.²

This determination enabled the inclusion, in a fast and extensive manner, of millions of Brazilian citizens as holders of rights to health care services, since, before this conquest, the population was unequally divided between a minority that had formal employment and enjoyed the health care services of public social security and those who had no formal employment link and, therefore, were considered as indigent or treated by means of public-selective health policies, mercy hospitals or direct payment (disbursement) for health care services.³

Prior to the onset of the SUS, the health care in Brazil was just understood as the absence of disease, thereby being directly focused to the actions of healing-based care. After implementation of this system, the concept of health started to assume a broad view, which allows us to consider the aspects involving the interaction of the individual with the environment in which it lives, as well as the socioeconomic and cultural conditions.²

The SUS has been governed by principles of universality, completeness, equity, decentralization, regionalization and hierarchicalization of network and of social participation, which converge its meaning for an idea of democratization of actions in health care services, by leaving to be centralized and, consequently, assuming the condition of decentralization.²

In light of the foregoing, the decentralization of SUS emerges as a way of ensuring participation in the construction and completion of health actions and services, and is grounded in the representation of the municipality, through municipalization, given its greater proximity to the reality of the local population and, consequently, greater understanding of its priorities and demands with regard to health care policies.² In this

context of accountability of the issue of health at the municipal level, in 1991, the Community Health Agents Program (known as PACS) was implemented and, subsequently, the Family Health (FH) was introduced, which had its onset in the year 1994, through the creation of the Family Health Program (FHP), which, in 2006, began to be called Family Health Strategy (FHS), which enabled the establishment of the phase of consolidation and understanding of continuity of the proposal. These services are coordinated by the Brazilian Ministry of Health with the purpose of guiding the organization of Primary Care in the country, in the sense of ensuring the principles of territorialization, longitudinality of care, intersectoriality and equity, with regard to the decentralization of care.⁴

The FHS incorporates, in its operation, the SUS principles and is structured from the Family Health Unit (FHU), under the understanding that it should be the preferential contact of users and the main “gateway” to the health service. The accomplishment of its work is conducted by a multiprofessional team, the FHS, consisted of, at least, physician and generalist nurse or a nurse specialist in Family Health, nursing assistant or technician and community health agents (CHA) Health, and it might be enhanced by the oral health professionals (dental surgeon and oral health technician). Besides these, pharmacist, social worker, physical education teacher, speech therapist, nutritionist, psychologist and physiotherapist might be integrants of supportive teams - Support Center for Family Health (known as NASF)-, according to the necessity of each community enrolled at the Family Health Units (FHU).⁵

Teamwork is a strategy for the development of actions that influence in the quality of health of the population, thereby generating bond, welcome, humanization of care and improvement in the access of users in relation to health care professionals and services.⁶

The implementation of the FHS is aimed at the proposal of care and supply of services of quality and continuity, which allow us to have an integrated view of the individual services, thereby enabling the care and follow-up of health conditions of women, men, children, adolescents and seniors. By considering the whole magnitude of composition of the FHS, the Program for Enrollment and Follow-up of Hypertensive and Diabetic People (HIPERDIA), created by the Brazilian Ministry of Health (MS), is one of the strategies inserted in the

FHU, which is aimed at reducing morbidity and mortality associated with systemic arterial hypertension (SAH) and diabetes mellitus (DM), at the same time in which it allows the enrollment, follow-up and guarantee of receipt of medications for people living with these diseases that are inserted among the chronic and non-communicable diseases (NCD).⁷

In 2001, with the purpose of comprehending the practical actions of care to users and their family members living with DM and SAH, the Plan for Reorganization of Care for arterial hypertension (SAH) and diabetes mellitus (DM) was developed, which is integrated to actions of the HIPERDIA program as aforesaid. This strategy proposed the establishment of goals and guidelines that could encompass actions for prevention, control, systematic treatment and diagnosis of such pathologies.⁸

Due to being diseases, where just the rehabilitation and promotion of better lifestyles can be established, these variants boost the NCD to be the diseases that require greatest amount of care shares, procedures and costs for health services.² Eating and living habits of the Brazilian population have been a matter of concern, since the modification linked to the scenario of urbanization, increased intake of processed foods and sedentary lifestyles have characterized risk factors responsible for the increased prevalence of NCD, among which the increasing rates of diabetes mellitus (DM) and systemic arterial hypertension (SAH) should be highlighted. Accordingly, in Brazil, the DM coupled with SAH is responsible for the leading cause of deaths, hospitalizations and lower limb amputations.⁹

Understood as a public health problem in Brazil and across the world, NCD have provoked relevant changes in the scenario of demographic and epidemiological transitions nationwide. Among the most prevalent consequences of NCD, cardiovascular diseases have traversed by a complex context, by showing that, in the 1930s, were responsible for only 12% of the causes of deaths and that, currently, they are characterized as the main cause of deaths in all Brazilian regions, accounting for almost a third of deaths.¹⁰

The diabetes mellitus is a set of metabolic diseases that triggers the onset of hyperglycemia, and might cause complications such as failure in eyes, kidneys, brain and heart, as well as in circulatory and cardiac systems. Among the different forms of diagnosis of DM, one can find the type 1, type 2, gestational, in addition to states of glucose

intolerance. The consequences arising from diabetes might be a result of changes occurred in the destruction of insulin-producing beta cells in the pancreas; insufficient release of insulin; disorders of insulin secretion; resistance in relation to the insulin action, among other changes.⁹

Regarding the systemic arterial hypertension (SAH), the pathology is considered a multifactorial clinical condition characterized by high and sustained levels of blood pressure (BP).¹¹ In order to establish the diagnosis of SAH, it is necessary to have the occurrence of measurement of BP during regular intervals, based on two or three measurements performed by health care professionals. The values must be directed to the measurement of systolic pressure greater than or equal to 140 mmHg and a diastolic arterial pressure greater than or equal to 90 mmHg, in individuals who are not taking antihypertensive medications.¹²

Due to being part of NCD and possess similar characteristics, DM and SAH are considered as an important challenge for the Brazilian Unified Health System (SUS) and for the scientific societies, which need to have a large knowledge in the face of situations of prevention and treatment of such diseases.¹³

In the scope of these actions, it is important to highlight that the actions linked to the attendance of users with DM and SAH will only be well-heeled if one establishes bonds of an integrated network of services and of professionals committed to the care, prevention and treatment of these users. Under this perspective, the nurse has the key role of acting, serving, performing activities in health education and service, promoting care and preventing injuries through their health care and managerial actions, which involve planning, scheduling, assessment and coordination of actions in the face of the approaches met in the HIPERDIA program.

When comprehending the seriousness of the Federal Law nº 8.080/1990, which has, among other principles and guidelines, the right of assisted people to acquire information about their health conditions, to the dissemination of information about the potential of health care services and their usage by users, we propose, in this paper, to inform the principles, the relevance and the workability of the Family Health Unit (FHU) for the local population, thereby seeking to sensitize it in relation to the importance of the FHU in the health care of the community.

METHOD

This is a descriptive study, an experience report, experienced by students of 9th semester of nursing at the Federal University of Bahia Reconcave (UFRB) in the practical implementation of the curricular component Supervised Traineeship I (ES-I), related to Primary Care, with a workload of 459 hours, in the hinterland of Bahia. Based on the pedagogical proposal of ES-I, the trainees must plan and implement an intervention project for the Family Health Unit (FHU) and/or community in which they are developing their activities.

The project is grounded on the identification of demands that need solvability in the internal/ external environment of the unit. In order to do this recognition, we had the contribution of community health agents (CHA) and of the nurse responsible for the FHU at stake. Thus, among the numerous mentioned situations, we chose to work with the local dissemination of the importance of the FHU in the community, as well as its actions and programs in the context of the Brazilian Unified Health System (SUS). This choice was strengthened by the report of CHA, who stated that the local population does not appreciate the importance of the insertion of the FHU in the neighborhood, including its principles and objectives, besides mentioning that some people do not properly appreciate the work and goal of these professionals and other components of the health care team with regard to the politics of health promotion and disease prevention.

For the implementation of this project, a discussion of this theme was initially conducted and, then, a schedule of presentation was constructed, by establishing the steps of explanation, its respective responsible and timetables; subsequently, an educational brochure-type material was produced with the themes SAH and DM, as well as there was the confection of "disposable little boxes" for the storage of medications for hypertension and diabetes.

In order to obtain the largest number of participants, we achieved a partnership of a physical educator, who spread the activity in the walking group for seniors by which it is responsible. Furthermore, we prepared posters that were placed at the FHU and the CHA distributed invitations in their respective micro-areas.

When starting the educational activity, we firstly performed the screening of the target audience with the measurement of blood

pressure and of capillary blood glycemia, proceeding to the elucidation of the theme with the presentation of professionals coming from FHU and NASF. Throughout the activity, we discussed about the arterial hypertension (SAH), the diabetes mellitus (DM) and the relevance of the Program for Enrollment and Follow-up of Hypertensive and Diabetic People (HIPERDIA), which is inserted in the schedule of attendance of the FHU. These morbidities belong to the NCD morbidity and are increasingly prevalent and incident in the country. These diseases are configured as a public health problem, considered chronic pathologies, which are stigmatizing and with high functional disability, thereby requiring ongoing assessment and follow-up, both from physicians and from the nurses by means of the aforementioned program.

In the contextualization of SAH and DM, we made use of ludic aspects to address these diseases, by performing a theatrical performance, in which the characters were represented by heart and blood vessels, thereby talking about the onset of hypertension and diabetes, symptoms and forms of prevention.

Next, the little boxes of medications were then distributed, as well as there was an explanation about the way of use for patients living with SAH and/or DM. The boxes were identified by images like the sun, representing the morning hours; the meal (lunch), representing the moment of the half-day; and the moon, which made reference to the night shift. Furthermore, folders were made available for the local population, which had information on health promotion and the prevention of complications in cases of SAH/DM. The activities were finished by means of the provision of a healthy snack containing fruits and natural juices.

RESULTS AND DISCUSSION

The project "Knowing the FHU and its actions" took place on 03/26/2013, at 3 P.M., lasting 03 hours, in an accessible and known place by all the local residents, with the presence of the following participants: 15 people from the community, the health team from the FHU (community health agents, a nursing professional and a dentist) and the adhesion of members of the Support Center for Family Health (NASF), who were represented by a pharmacist and a social worker.

The discussion had bidirectional approach, with various questionings, where we seek greater interaction with the group. During the project execution, we realized the active

participation of the public, which showed the learning of the common sense on the explained theme.

From the aforementioned, there were discussions about the history prior to the onset and establishment of the SUS, through the contemplation of the socio-political context of that time. Accordingly, from the reports, we have verified that the SUS was restricted to health institutions such as the “health station” and the hospitals, which denotes that there was ignorance in relation to other establishments that integrate this health care network.

We have realized the receptivity of the group to broaden its knowledge with regard to the importance of the proposed activity and the accomplishment of health education in the community; as well as the recognition of the importance of FHU for the local community and of professionals who comprise the health care staff at the primary level; and the discussion and clarification of numerous uttered doubts about the operation and structure of the FHU.

The participants were predominantly hypertensive and diabetic, and held prior knowledge about these pathologies, but showed up questionings about the onset of the illness and the complications of SAH/ DM, being that they were immediately clarified about such topics. The execution of the theatrical presentation was the tiresome moment of our activity, since the public fully participated during the speeches of characters, by telling us about their experiences.

Upon knowing that there are numerous misconceptions concerning the right treatment at the right schedule, we launched the distribution of “little boxes” as a strategy to reduce such mistakes, through which we explained the purpose and the function of these objects. People reported the enthusiasm in receiving and putting into practice the aforementioned “little boxes”. At that time, we enjoyed the opportunity to advise on the health care, prevention of complications arising from the diseases and the rational use of medications.

At the end of the activities, a “healthy snack” was offered, which marked a moment of relaxation and strengthening of the educational action; of enhancement of self-care, especially on the quality of the eating habits of people with SAH and/or DM; and the incentive for them to continually attend the HIPERDIA program, through the attendance with the nursing professional, because it was

found a poor adherence in relation to the consultations.

FINAL REMARKS

Health education encompasses the axis of health promotion and disease prevention, thereby meeting the principles of the SUS and the National Primary Care Policy (known as PNAB). The completion of this educational activity provided a closer approximation of the health team of the FHU at stake and of the trainees of nursing with the local community, which allowed the identification of the prior knowledge of the participants about the Brazilian health system and the explanation of the magnitude of the SUS, thereby demonstrating that the FHU is the beginning of the network that covers the entire context of health care.

This strategy is a means of encouraging the FHU to know the reality of residents and the health situations in which they are inserted and, from this context, seek to develop their actions targeted to the local necessity. As the community becomes aware of the importance and role of this service in its territory, the health care is conducted in a more effective and active manner, even within the limitations of the SUS regarding the management/administration of the health system in the three government spheres.

It is worth highlighting that the health education must be carried out continuously, regardless of the available economic and/or human resources, because it might be individually or collectively performed and by all health care professionals in the three levels of complexity of care.

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