

Use of health technology in primary health care in approach to hypertension

Uso das tecnologias em saúde na atenção básica às pessoas em condições de hipertensão arterial sistêmica

Uso de la tecnología de la salud a personas en condiciones de la hipertensión en el atención primaria de salud

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ABSTRACT

Objective: Analyze the use of health technologies in the work process to hypertension undertaken by professionals in the primary health care. **Methods:** A qualitative study, executed with 22 professionals from in six units of the Family Health Teams and Health Support Center Family of a Brazilian town. It was used for data collection semi-structured interview, and as data analysis technical, content analysis. **Results:** The results show that the care of hypertension is also medical-centered, based on spontaneous demand and the use of hard technologies. The protocols have not yet been deemed necessary tools for organization of care and relational technologies need to be strengthened to perform the care user-centered. **Conclusion:** It is necessary to carry out the principles of the unified health system and the use of appropriate technologies in health care for every moment.

Descriptors: Primary Health Care, Health Care, Biomedical Technology, Hypertension.

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RESUMO

Objetivo: Analisar a utilização das tecnologias em saúde no processo de trabalho empreendido pelos profissionais da atenção básica na abordagem à hipertensão arterial sistêmica. **Métodos:** Pesquisa qualitativa, realizado com 22 profissionais de seis unidades da Estratégia de Saúde da Família e do Núcleo de Apoio à Saúde da Família de um município mineiro. Utilizou-se como fonte de evidências a entrevista semiestruturada e, como técnica de análise dos dados, a análise de conteúdo. **Resultados:** Os resultados demonstram que a atenção à hipertensão ainda é médico-centrada, baseada na demanda espontânea e na utilização de tecnologias duras. Os protocolos ainda não foram considerados instrumentos necessários para organização da assistência e as tecnologias relacionais necessitam de serem fortalecidas para realizar o cuidado centrado no usuário. **Conclusões:** É necessário efetivar os princípios do Sistema Único de Saúde e a utilização das tecnologias em saúde adequadas para cada estação do cuidado.

Descritores: Atenção Primária à Saúde, Cuidado em Saúde, Tecnologia Biomédica, Hipertensão.

RESUMEN

Objetivo: Analizar el uso de tecnologías de la salud en el proceso de trabajo realizado en atención primaria de salud en el enfoque de la hipertensión. **Métodos:** Investigación cualitativa realizada con 22 profesionales de seis unidades de la estrategia de salud de la familia y el centro de apoyo a la salud de una ciudad. Fue utilizado como evidencia de los datos la entrevista semi-estructurada, para el análisis de datos, el análisis de contenido. **Resultados:** Los resultados muestran que la atención a la hipertensión es médico-centrada, en base a la demanda espontánea y el uso de tecnologías duras. Los protocolos aún no se han considerado las herramientas necesarias para la organización de la atención y las tecnologías relacionales deben reforzarse en el cuidado de usuario. **Conclusiones:** Es necesario poner en práctica los principios del sistema único de salud y el uso de tecnologías apropiadas para cada estación en el cuidado.

Descriptores: Atención Primaria de la Salud, Cuidado de la Salud, Tecnología Biomédica, Hipertensión.

INTRODUCTION

The majority of Primary Health Care (PHC) services are inserted in an epidemiological reality that has as characteristics the predominance of chronic non-communicable diseases (NCDs), responsible for almost 3/4 of causes of death in Brazil, being systemic hypertension the most prevalent NCDs, whose prevalence is 24% of the Brazilian adult population (26.3% women and 21.5% men).¹

Given this information, hypertension is one of the strategic areas of PHC activity services that should offer actions that promote health monitoring through the first contact access, the longitudinality and the comprehensive care, the care coordination among the remaining levels of care and family and community inclusion in addressing the problem.²

The Ministry of Health (MH) recommends that the actions for the proper management of hypertension should be supported in three areas: surveillance of

hypertension with its comorbidities and determinants; comprehensive care; and health promotion.³ Studies show that attention to hypertensive patients in PHC services still comes down to the supply of medicines, laboratory tests, and medical appointments.⁴⁻⁵ Thus, it is evident the need to redirect the performance of health workers, strengthen health promotion strategies and prevention of complications and organize the healthcare network for chronic noncommunicable diseases in the context of comprehensive care to the user living with hypertension.

In this regard, the MH understood the need to redefine the network of care for NCDs, putting primary care as care coordinator. So, decree n.483 / 2014 was published and it aims to organize the care lines and meet the needs of people with NCDs, guaranteeing their access to health promotion, prevention of risks and complications, diagnosis, treatment, and palliative care.⁶

From the perspective of managing the care lines, authors state that investments are needed in the organization of monitoring the health needs of the population; the organization of health information systems; intersectoral coordination; the covenant of the performance of different levels of attention in the surveillance of NCDs; the use of protocols that support the service in the “care stations”; as well as in the implementation of activities aimed at community for health promotion and diseases prevention.⁷

The care lines constitute the assistance flows guaranteed to meet the health needs of users in the network, even if the points of attention are not formally constituents of the health network. They work not only by established protocols but “also by the recognition that service managers can combine flows, reorganizing the work process in order to facilitate user access to Units and Services they need”.^{8:1}

Thus, given the need to reorganize the care lines of users with NCDs and involve the responsibility of the teams by the user’s walk through the network, authors propose changes in the work process so the user will be addressed in the network in a unique way and with the use of appropriate technologies (light, light-hard and hard technologies) for each “care station”, ensuring accountability, linking and comprehensive care.⁷

In micropolitics of health working process, the team must provide a focused assistance on the user and his family, developing interdisciplinary actions to actualize the assistance in accordance with the care line from the perspective of building a comprehensive care plan.⁷

Considering that the Unified Health System (UHS) recommends building the care lines for NCDs; that PHC should act as coordinator of the health care network; that the working process of NCDs should be founded on the principles of comprehensive care, attention and coordination

longitudinality; and that hypertension is the most prevalent NCDs, we ask: which health technologies are adopted by PHC professionals in the care of users with systemic arterial hypertension?

We have adopted, as presupposed, that the organization of daily work to care for people with hypertension is associated with the use of health technologies for each “care station”, which can result in different forms of attention.

The aim of this study is to analyze the use of technology in health working process undertaken by PHC professionals in approach to hypertension in a city in the Midwest of Minas Gerais.

METHODS

This is a study of qualitative approach, an approach in which researchers emphasize the constructed social reality, the values of human experience, the qualities of the processes and their meanings.⁹ To understand and interpret this reality, researchers substantiate this study in health technology framework, where light technologies are relational, as the reception and sensitive listening; the light-hard are well-structured knowledge that operates in the health work process, such as clinical medicine and epidemiology; and hard technologies are equipment, organizational structures.¹⁰⁻¹

This study took place in a city in the Midwest of Minas Gerais that has 100% of the population covered by the Family Health Strategy (FHS) and the Support Center for Family Health (SCFH). The research had six teams of FHS, with a diversity of territory because it was urban teams and two rural teams, with differences in health social production as the rural teams are itinerants presenting as a difficulty the distance traveled by health professionals and roads in bad conditions. Rural communities have small and poor health facilities where services are provided in weekly or monthly schedules. It is important to emphasize the lack of public transport in these rural communities where the transport of users is regularly performed by ambulance for routine consultations and laboratory tests in the head office in the city. SCFH was also included as a research setting.

The study included 22 professionals: one doctor, five nurses, six nursing technicians, nine community health agents and two professionals of the Support Center for Family Health (physical educator and a nutritionist).

As criteria for participation in the study, were chosen doctors, nurses and nursing technicians who work for at least six months in the FHS teams; a Community Health Agent (CHA) of each FHS with minimum performance of a year in the territory and all SCFH professionals (consisting of physical educator, physiotherapist, nutritionist, and psychologist). All participants who met

the inclusion criteria were selected to participate in the study.

It was used as a source of evidence the semi-structured interview that was guided by a script that contained two sections, the first included the characterization of the participants and the second included specific questions that addressed the research problem.

Data were collected between April and July 2015. Interviews were conducted in the work environment, in a private room and individually through a semi-structured guide and fully recorded. The interviewed people were identified by the letter “I” (interviewed), followed by the number of the interview order.

For data analysis, we used the content analysis technique, which exposes the “meanings”, according to the stages: pre-analysis, exploration of material, treatment of results, the inference, and interpretation.¹²

The study followed the ethical recommendations of Resolution 466/2012¹³, approved by the Municipal Health Secretary in the city the research was taken and by the Ethics and Research Committee of the Midwest Campus Dona Lindu, of the Federal University of São João del Rei (CEPES / CCO) - CAAE 41771615.0.0000.5545.

RESULTS AND DISCUSSION

The nomenclatures of the Family Health Program (FHP) and the Family Health Strategy (FHS) were used in this article to describe the same process work, but that happened at different times of the articulation of public health FHS terminology because they considered important to treat it as a political-care strategy for the establishment of a new logic of health care.

The results show that primary care units are a reference to the enrolled population and make up the priority gateway for users in the healthcare network, but the care to users in hypertension conditions appears fragmented and configures that the service is mainly facing spontaneous demand (I2, I3, I5, I7, I8, I21). It was evident that the PHC professionals recognize hypertension as one of the priority diseases, however, there are difficulties in putting into practice the official recommendations for the organization of work, as the user’s risk rating in hypertension conditions, programmatically distancing the attention by professionals from the FHS teams.

There is no specific program in the unit for hypertension and diabetes, what exists is a routine that we do in relation to patient attending. The FHP works as follows: 50% is by spontaneous demand, but there is no classification according to the guidelines. (I7)

It was also reported that the team develops actions for the population according to local demand. Regarding attention

to hypertension, one respondent said that a systematic monitoring is not carried out for hypertension users by the teams, and proposes as a probable cause the non-surveillance by the municipal health management.

The reality is that they do not charge us. We simply work according to what they direct us. It's like the master plan, they charged the master plan, everyone accomplished the planned schedule, hypertension medical consultation, the whole plan. Now, unfortunately, they are not charging anything (...). There is a long time I don't hear about HIPERDIA [hypertension and diabetes mellitus control program], I'm not charged about HIPERDIA unfortunately (...). Are there some phases of the service they charge more, right? At the moment they are charging too many exams. But about HIPERDIA, unfortunately not. (I3)

The attention the user with hypertension is still doctor-centered, with a curative focus and based on hard technologies, placing the request for laboratory tests and drug therapy as key strategies for monitoring and treatment of hypertension.

The receipt is renewed in every six months. When it is time to renew the recipe the patient comes to the appointment, I ask for routine exams, if the patient is already diabetic I also ask a battery of tests, when he returns with the exams I see if it needs to change the medication or not. (I21)

It was stated that the continuation of drug therapy is done regularly through renewing the recipe without medical consultation to assess the effectiveness of treatment.

Here in the unit, we know that is not right because the recipe should be written with the presence of the patient, but it does not happen, unfortunately. (...) The reality that I know, usually a 60 to 70 recipes per week. So the doctor makes appointments this morning and in the afternoon she won't make appointments and will make recipes' renewal. Then she uses the medical records. The patient that do not show in appointments for a long time doesn't get their recipes renewed. (I3)

This is due to factors related to the management at the municipal level and the organization of the working process of each FHS team that prevent the realization of care management to the user according to the guidelines of the MH (I1, I3, I13). The operational difficulty to stratify these users according to risk rating also difficult to identify and proper monitoring cases of hypertension at higher risk for complications (I7). The

nurse, in the process of work, has difficulties to act more significantly in performing nursing consultations to people in hypertension conditions.

I still could not win the trust of the population, because people think that you will schedule a nursing consultation that you do not ... kind of know nothing, I will not do anything. So I think they still failed to recognize, but I think my job's still a bit flawed because I still can not cover the entire population with hypertension. (I8)

A hard technology that has not been exploited by the city is the nursing protocol, factor pointed out by nurses as a problem of its operations in PHC. (I3, I5, I7, I8, I13, I21)

But I have a very big problem, we do not have nursing protocol and this affects me a lot because I can not ask for the tests (...). The protocol is a problem since when I arrived here, but I think management is not in favor of nurses having this autonomy. (I3)

It is noteworthy that, in the nurse's role in the planning of educational groups along SCFH, each team has its own strategy for the organization of groups, and mostly develop lectures to transmit knowledge to patients vertically about the health-disease process.

It's a personal thing, it's not methodological, not scientific, it is an operating group. I use a simple vocabulary, I also use the Health Ministry manuals to assemble presentations, that has the topics that I follow, because as we always have new members, they keep asking what is hypertension in the lectures... then it turns out that many of the lectures are even repetitive because we are always taking new members, and because they are a carrier if the disease but they do not know what it is. (I13)

Although these strategies are incipient to promote behavior change, some professionals have noted the need to use new features to encourage the user participation and the active search for new cases in the community. The exchange factor appears as a way to have the presence and not the bond.

I try sometimes to give a toast. Yesterday I took a photo group and gave it to them because it was Mother's Day. One user said to me, "it is the best mother's day gift" because her granddaughter was with her in the picture. So she loved, and it's like this: they feel good and when we see, we feel even better, we realize this is generating results. (I11)

This week I had a case of hypertension in adolescence, so became an interest of going in schools, she discovered in the screening, she came to routine consultation, came to show the preventive that was done independently, came here and I measured the arterial pressure, the technician too and the doctor too. As I detected an alteration in the arterial pressure, I immediately spoke to the doctor to see her, asked for the exams, I gave her an oral medication and the pressure normalized. (I13)

Individually, orientations are held every care step, but as prescriptive nature, which ignores the user's singularity. It is notable, too, the use of light-hard technologies for these guidelines, such as the construction of leaflets.

They [guidelines] comes ready in a paper, we have scheduled. This orientation was done by a nutritionist, and all information come ready in a paper. (I5)

The guidelines that are carried out by the team also fail to stimulate the user as the protagonist of care, concretizing the non-sensibilization for self-care:

As they say, if we persist we can do it, eventually we can polish these people to come in daily routine to accept that he has hypertension because the person has the disease but does not accept it, the patient that has hypertension does not accept saying that he has the disease. (I1)

For the nursing technician participation in the user's attention in hypertension conditions, respondents said that their work is based on the measurement of blood pressure, the moment they use to guide the patient, usually, prescriptive and punitive manner. Also reported following the CHA during some home visits.

There are people that we have to go to the house to measure the blood pressure because they have difficulty coming to the FHP, we do home visits with the measurement of pressure and the user and family guidance, this is the way it works in here. (I2)

The CHA is recognized both by himself and by the other team members, such as the link between the team and the community by being inserted into the daily lives of the population (I12). Thus, part of the unit's work process depends on the health demand that CHA brings to the team and is also responsible for checking and supporting the implementation of guidelines and the use of medications in the family environment of the user with hypertension.

They are patients who need more guidance on medications, patients that you see that has a limited understand-

ing about medication, then the health worker is going your home more routinely to advise on the use of this medicine, if you are taking it correctly, or if you are not. And this health worker raises these needs, he brings to us, then we evaluate and make this visit. (I7)

Through the visits they [CHA] bring us who are new in the area, for example, arrived a new hypertension patient, has come from other FHP, already have a diagnosis, is already being medicated, then we start to make the attendance. (I4)

Besides the need to create bonds and be the bridge between the people and the unit, the CHA must achieve goals in monitoring people with hypertension (I2) and conduct guidelines that mainly aim to change lifestyle habits (I1, I4, I8, I12, I13, I14).

We have to know how to get there, this is a step by step process, you will persist until the patient realizes ... we have a great support from the nurse, who helps us, that tougher person, then we ask to come to the unit, then the nurse guides, the technicians guide too, we have a great support when we meet resistance, and gradually they are taking the medicine straight, because they will see it does not have another way... you have to take it right, so is easy to get them to take it without pressing, just talking. (I12)

The FHS rely on the support of SCFH professionals to conduct promotion, prevention, and control of hypertension, which has been primarily employed at the individual level, which sometimes leads to work overload. In addition, the meetings to discuss cases end up getting damaged due to the high demand of actions focused on the individual (I5, I3).

The SCFH needs to function as a truly SCFH because it is a support to the FHP and is not so much individual attention, is more collective service, and here the individual works more than collective. (I5)

The professionals who participated in this study pointed the following complicating factors of the performance of PHC of people in hypertension conditions: cultural factors of the population (I8), lack of professional training (I1, I4, I5, I7, I8, I12, I13, I19, I21), work overload (I1, I2, I4, I11, I13, I14), staff turnover (I7, I13, I14, I21) and low user compliance (whether pharmacological or not) and the difficulty to involve the family in the care (I1, I2, I3, I5, I8, I11, I19, I21).

We try to do a search, but from the moment that they have some resistance we do not have much to do. We have patients that sign a term refusing the treatment,

we had a pressure case 21, "Ah, my blood pressure is like that", then says, "no, I will not" (...) we always try to do active search, if the patient does not adhere we ask to sign the term. (I8)

What hampers a little is when the agent who is not prepared, I have a lot of new agents, so it is difficult to follow up the unit routine, my advantage is that they are from the area, so they already know users. The CHA enters in health area without being able to act there, and the agent knows what hypertension is? Before you visit have to be inside of it, knowing to guide, is being something mechanical, the agent has to know, the agents turnover is high, starts then quit the job, it does not work ... (I13)

The health working process in the UHS is still strongly marked by elements of the biomedical care model, which reduces the professional approach only to the disease that the user has, without incorporating, in practice, the principles and guidelines that support the new paradigm of health care proposed for the UHS since the health reform.¹⁴ One of the central contemporary confrontations of the health care model crisis is the need for reconfiguration of the working process regarding chronic conditions, that in the actual model it has been following, in general, the logic of attention to severe conditions,¹⁵ making health unit similar to a "clinic"¹⁶, i.e. a physical space in which professionals provide health care.

In Brazil, such changes occur towards the implementation and assessment of the health practices in order to sustain a reasoned assistance on the principles of universal access to services, comprehensive health care and equity in service to the population, which are components of current national policy, called UHS. The attention on the FHS should be based on interdisciplinary actions organized in a defined territory, seeking to improve living conditions and health. However, in practice, this strategy has not yet achieved its goals in PHC, because the assistance is still based on the biomedical model, focusing on disease and fragmented care.^{17:100}

In this regard, we see the maintenance of health services organized to serve primarily to spontaneous demand, producing a care that tends to be restricted to an individualised medical care and even in primary health care,¹⁶ where the service is expected to be centered on the user and his family, prioritizing collective and planned actions as the users risk rating.¹⁸

Knowing the epidemiology of hypertension and the need for qualification of the NCD approach strategies, the agencies responsible for the formulation of public health policy published, in 2013, technical and operational

manuals that have the aim to reorganize the attention to hypertension under the primary health care.^{2,18} However, the city studied does not use these recommendations to guide the practice of PHC services yet (such as risk stratification of users with hypertension, for example), which has negatively influenced the organization of care lines as prescribed by decree n. 483 / 2014.⁶ This decree confirms that PHC should perform diagnostic, screening, and treatment actions according to clinical guidelines recommended by official health agencies; be coordinated with other sectors for the implementation of prevention of chronic diseases and health promotion; be the coordinator of care (even when referenced to other network components) and ensure full and careful monitoring and evaluation.⁶

Studies show that when the work process is reorganized and operated focusing on needs and demands of users and their families - not sickness and procedures - and all professionals being involved in comprehensive care, there is a solution or a problem minimization, reducing the "hard technologies" use such as examinations and procedures.^{7,16}

Thinking of health care in an integrative way "is refusing to reduce the patient to the biological system or the complaint that supposedly produces suffering, so interdisciplinary health action becomes necessary for an approach that accounts for effective responses".^{17:105} Thus, "when all team members know the needs of individuals and families, the approach is total and is more effective because the entire team participates in the follow-up".^{19:244}

As evidenced in the results, from the moment in which professionals summarize the user monitoring in hypertension conditions to simple prescription renewals, there is a gap in the doctor-patient relationship, which makes more difficult to stimulate the user's autonomy and the co-responsibility and the construction of the link, as the assistance becomes a mechanical act, repetitive,²⁰ a factor that disintegrates the care.²¹ This work process reveals a relationship where the disciplinary power²² operates defining spaces, relationships and where scientific knowledge and professional decision are sovereign, reducing drastically and dramatically the possibility of user participation in the design of their therapeutic plan.¹⁴

A study conducted in a city of Bahia has also identified the high consumption of light-hard and hard technologies practices in attention to hypertensive patients and noted a certain weakness of PHC professionals in performing sensitive listening to the person with hypertension, giving voice to their demands and needs, a result that, for authors⁵, continues as one of the main challenges to change care practices for hypertension: focus care on the user and not on procedures.¹⁴

The organization of "live in action" work is directly influenced by micropolitics¹⁰⁻¹ issues and it is necessary that

health professionals identify new senses in care production, taking light technologies as guides for the use of light-hard and hard technologies.¹⁴

A strategy to promote care that is not fragmented and focused on the disease is the implementation of systematized nursing consultation that is guided by a theoretical framework and performed according to the nursing steps²³ based in the family-centered, which is a technique capable to encourage the active participation of the family both in the direct care of the user, as in social participation, linking scientific knowledge to the family knowledge for the construction of the care plan, in order to favor the self-care.²⁴⁻⁵ The nursing process is an instrument that guides the care provided by nurses in all health care levels and is recommended to be implemented in public and private services.²³ Therefore, the realization of nursing consultation may not be dependent only on the presence of the municipal nursing protocol as nurses have a background knowledge descendent of the profession. Authors argue that “transform each protocol in a tool, not a doctrine, is the key to the management of intercessory relations that produce care”.^{7: 598}

A study from 2011 emphasized the importance of consultation by nurses in the care of hypertensive patients in a systematic way, since systematizing the nursing consultation has as main objectives: to organize the approach to the user from the identification of risk factors to interventions, set the role of the nurse and make this function of professional and differential character within the unit, since municipal protocols are not required to perform the steps of the nursing process.²⁶ The systematized nursing consultation, whether individual or collective, is an important tool for monitoring the person with hypertension and the achievement of health education for self-care, since knowing the care needs for each patient, we can perform the care planning, agreeing goals, offering elements and strategies so the user can feel more active in the health-disease, respecting the cultural and economic characteristics and involving family in care.²

Regarding collective activities for health education, the literature shows that it is necessary to use new methodologies, as opposed to the classic pattern of vertical transmission of knowledge, in other words, renew the modes of communication between professionals and users that favor active participation of the group members.²⁷

The strategies adopted in carrying out collective activities are directly related to the promotion of user self-care, as well as in their active participation in your care and your community. Also, involve the user's family strengthens monitoring and willingness to the self-care.²⁸ A study corroborates the results of this research showing that the main issues discussed in

educational groups are: 1) drug treatment, 2) physical activity and 3) the pathophysiology of hypertension and diabetes, disregarding psychospiritual factors and knowledge sharing between participants, revealing that the minority uses interactionists methods that allow greater involvement of users and stimulate their self-care.²⁹ This shows that health education is carried out in a prescriptive way, “disguised as care”, with poor solutions across the health needs as it requires, as a doctrine, life habits that should be adopted by the user¹⁴ as shown in quoted saying: “soft water in hard rock both hits until it sticks” (I1).

Research has shown that the low interest of users to preventive actions; the lack of trained staff and high turnover of professionals are factors that directly influence the preparation and development of group activities.²⁹ Poor adherence is probably due to the cultural factor that carries the curative focus and the great value that is given to medical appointments, thus increasing demand for care and medical procedures prevents the development of other activities. In addition, the majority of the population is unaware of the true role of PHC. Therefore, disregard the importance of new strategies for the promotion of comprehensive health care.¹⁶

In contrast, a study verified that the PHC has achieved better results related to change in lifestyle in relation to secondary care services, probably because they are closer to the user's reality, even when both services adopt educational strategies that work the users' autonomy.³⁰

In this regard, the CHA work can be considered as a positive factor for the link establishment between the population and the unity and the conduct of the teamwork.³¹ When attending a person with hypertension, it is expected that the CHA, when producing home care, orient the community about the prevention of NCDs and health promotion; perform the tracking of new cases of hypertension and monitor the implementation of the care action plan that was agreed with the health team.¹⁸ However, CHA work process becomes mechanical and not so effective when it is guided by the purpose of performing the number of visits to achieve goals and for the passage of pre-established information.³²

It was also highlighted a mechanical action of nursing technicians in attention to users with hypertension, developing actions only about the disease, establishing a link with the user who is centered on a procedure: blood pressure measurement. This moment could be used to provide a better user understanding of hypertension, facilitating their autonomy from the disease and the achievement of the objectives and goals of treatment, according to the therapeutic plan.¹⁸

As a strategy to meet the demands not achieved by the FHS, and pursuing the realization of services in the health care network, SCFH also operates in the care actions,

but with weaknesses that still need to be adapted, as the workload and low availability for meetings between teams, which limits the performance of joint actions.³³⁻⁴ Authors also point out that the wrong operation of the SCFH – where the individual care is still prioritized - does not favor the discussion of cases and integration of this action to the routine of the FHS teams since it requires availability, professional attitude, and partnership.³³⁻⁴ In this case, the SCFH is seen as the solution to the high demand for consultations and procedures³⁴ (producing a care that does not go beyond the problems to be solved) and not as a partner to develop, together with the user and the staff, a care plan.¹⁴

According to authors, to change the care model is necessary a situational analysis of health for a given area so municipal or state actions and protocols can be effective against the local reality, especially when it comes to NCDs in the quality of life.⁷ The comprehensive care regarding an NCDs such as hypertension, is only obtained in the network, through the articulation among the other levels of care when the individual goes through every care station, it is up to these professionals the challenge of connecting each component to the network of health attention.⁷ However, as a professional from FHS, you can make changes through qualified work, work the team goals and creativity of each professional are ways to act in the micropolitics seeking reorganization of the work process, which finally will bring a new approach to health.³⁵

Among the many challenges that PHC must overcome, the lack of preparation of professionals to work with NCDs is an issue that needs immediate attention, both due to demographic and epidemiological dimension and by attesting the failure of the biomedical care model and its potential to generate change in health paradigm. A staff attentive to changes and able to work in this scenario should be able to permanently review its working process since it maintains the centrality of their practice on the demands and needs of the user. In addition to the lack of professionals able to build a horizontal relationship with the people in the service who participated in this study, is still poor in higher education the preparation of the professional to act with NCDs, particularly in collective scope of interventions, because since their academic experience the professional already understood that knowledge is only passed vertically. It is also necessary the training of these professionals in order to sharpen the questions about the team failures and the health care network as a problem for the user's adherence. In this regard, most health professionals working in primary care plays in their daily practice the same model as experienced in

its course, resisting having new resources to achieve the goals of PHC.²⁹

FINAL CONSIDERATIONS

The results of this study showed that the use of health technology by the FHS teams is mainly supported by hard technologies uses less light and light-hard technologies, that does not attend the purpose of the work process to serve the people in hypertension conditions within primary care.

It is also shown that the effectiveness of the use of light and light-hard technologies depends on the determination and health organization's support at the municipal level and professional work in interdisciplinary actions seeking to produce a care that, relating to the user, release the "live-work". Thus, it is confirmed the study's assumption because, although the professionals identify hypertension as a priority in the actions of PHC, the results showed that the service is organized spontaneously according to the disease demand. As a limitation of the study, we identified the definition of participant inclusion criteria, which made it possible to interview only one doctor.

The determinations of agencies' manuals responsible for the formulation of public health policies, considered a hard technology, are not seen as an instrument for the implementation of the work process. It was found that the absence of municipal nursing protocol caused a stiffening of the profession performance, characterizing a "dead work" including without prospects, within everyday experience, to produce a "live-work."

The professional activity presents difficulties and the lack of preparation to carry out the user-centered care since the focus of the action is still in the disease and there are limitations of professionals to consider the user's singularity and perform family approach.

Thus, it is believed that the first step in the reorganization of attention is the training of professionals so that connoisseurs of ways to enhance attention can work in a interdisciplinary and intersectoral approach not only in relation to treatment and maintaining health, but also act more actively in the prevention of risks and promoting health. However, we should considerate health education as a way to share knowledge using horizontal and dynamic models, breaking paradigms in PHC when it comes to health education.

Facing the difficulties of working hypertension, a multifactorial disease which depends on lifestyle changes for its control, PHC needs to invest in improvements in health care that require the interrelation between the macro and micropolitics, overcoming the main weaknesses

– professional turnover, dynamic in the professional / user relationship and innovations in health education - that influence the user to not feel co-responsible for their health.

Although the collective work is needed, we consider the importance of individualized attention when implanted the nursing consultation and when based on a scientific methodology that identifies the main problems through sensitive listening, which may contribute to the nurse, together with the team, to plan interventions that respect the individuality and their family relationships, as well as a start to the user's construction of autonomy.

In conclusion, it is essential to make changes in health work process, seeking the realization of the UHS principles and the use of appropriate health care technologies for each care station.

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