

FAMILY HEALTH STRATEGY IN PRIMARY HEALTH ACTIONS FOR SYSTEMIC ARTERIAL HYPERTENSION PATIENTS

ESTRATÉGIA SAÚDE DA FAMÍLIA NAS AÇÕES PRIMÁRIAS DE SAÚDE AO PORTADOR DE HIPERTENSÃO ARTERIAL SISTÊMICA

ESTRATEGIA SALUD DE LA FAMILIA EN LAS ACCIONES PRIMARIAS DE SALUD AL PACIENTE CON HIPERTENSION ARTERIAL SISTÉMICA

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Submitted on: 08/09/2012 Approved on: 09/26/2013

ABSTRACT

The Family Health Strategy (FHS) is based on health surveillance, containing the characteristics of both interdisciplinary and multidisciplinary actions. This program also operates in specific population groups, such as those with systemic arterial hypertension (SAH). This qualitative research aims to enhance the primary health care actions for patients with SAH, reported by the family healthcare team, highlighting the interventions developed by nurses. This is a descriptive study of the actions performed by nursing professionals within the FHS and was conducted with six members of the FHS from a city in the countryside of the state of São Paulo. The doctor emphasizes his role within the program and characterizes the work of the nurse's aide and of the nurse herself as "help" in receiving the patient. Community health agents value the home visit, where they can do their "promotion". The team recognizes that nurses perform a wide range of activities in the clinic and that they know the program as a whole, but they are overburdened with administrative issues. Health education for the prevention of SAH is still in its initial stages. Among the identified activities, priority is given to those that are strictly geared toward a cure, with parameter controls, as set forth in the SAH protocol, in which there is still no clear view on the part of the team members concerning the work processes necessary to ensure the integrity of actions. It can therefore be concluded that the nurses' role in the FHS faces difficulties and challenges, especially as regards their activities, distribution of responsibilities, working conditions, and interdisciplinary relations.

Keywords: Public Health Care; Nursing; Systemic Arterial Hypertension.

RESUMO

A Estratégia Saúde da Família (ESF) tem como princípio a vigilância à saúde, tendo como característica a atuação inter e multidisciplinar. Atua também em grupos específicos da população como os portadores de hipertensão arterial sistêmica (HAS). Objetivou-se nesta pesquisa qualitativa levantar as ações de atenção primária à saúde do portador de HAS relatadas pela equipe de saúde da família com ênfase nas intervenções desenvolvidas pelo enfermeiro. Trata-se de um estudo descritivo sobre as ações dos profissionais que compõem a ESF. A pesquisa foi realizada com seis integrantes da ESF de uma cidade do interior do estado de São Paulo. O médico destaca o seu papel na unidade e caracteriza o trabalho da auxiliar de enfermagem e do enfermeiro como uma "ajuda" na recepção do paciente. Os agentes valorizam a visita domiciliar em que ainda fazem a "promoção". A equipe reconhece que o enfermeiro tem inúmeras atividades na unidade e que conhece o programa como um todo, porém está sobrecarregada com questões administrativas. A educação em saúde para a prevenção da HAS ainda é incipiente. Entre as atividades levantadas, priorizam-se aquelas de cunho estritamente curativas, de controle dos parâmetros, que são indicadas no protocolo da HAS, nas quais ainda não há uma visão clara, por parte dos integrantes da equipe, sobre o processo de trabalho para a integralidade das ações. Conclui-se que o papel do enfermeiro na ESF enfrenta impasses e desafios, especialmente no que diz respeito à sua atuação, divisão de responsabilidades, condições de trabalho e relações interdisciplinares.

Palavras-chave: Saúde Pública; Enfermagem; Hipertensão Arterial Sistêmica.

RESUMEN

La Estrategia Salud de la Familia (ESF) tiene como principio la vigilancia sanitaria; su característica es el trabajo interdisciplinario y multidisciplinario. Actúa también en grupos específicos de la población como los de los pacientes con Hipertensión Arterial Sistémica (HAS). El objetivo de esta investigación cualitativa fue identificar las acciones de atención primaria de las personas con HAS realizadas por el equipo de salud de la familia y describir las intervenciones llevadas a cabo por el enfermero. Se trata de un estudio descriptivo sobre las acciones de los profesionales que componen la ESF. La investigación fue realizada con seis miembros de la ESF de una ciudad del interior del Estado de San Pablo. El médico realza su rol en la unidad y define el trabajo del auxiliar de enfermería y del enfermero como "ayuda" en la recepción del paciente. Los agentes valoran las visitas domiciliarias donde aún "promocionan" la salud. El personal reconoce que los enfermeros tienen demasiada tarea y que conocen el programa

pero que están sobrecargados de asuntos administrativos. La educación en salud trata poco el tema de prevención de HAS. Entre las actividades analizadas, se les da prioridad a aquellas estrictamente curativas, de control de parámetros indicadas en el protocolo de HAS. Los integrantes del equipo aún no tienen una visión clara del proceso de trabajo que busca integrar las acciones. El papel del enfermero en la ESF enfrenta dilemas y retos, principalmente en lo referente a su actuación, división de responsabilidades, condiciones de trabajo y relaciones interdisciplinarias.

Palabras clave: Salud Pública; Enfermería; Hipertensión Arterial Sistémica.

INTRODUCTION

Systemic Arterial Hypertension (SAH) is a serious epidemiological issue in Brazil, both due to its high prevalence in the adult and elderly populations, as well as to the complications that it can cause in the form of high morbidity-mortality rates and relevant impacts on hospital, social security, economic, and social costs. It is a syndrome which stems from a multifactorial origin characterized by the increase in blood pressure, giving way to cardiovascular and metabolic abnormalities.^{1,2}

International data estimate that this disease affects nearly 50 million people in the USA and 1 billion worldwide.² In Brazil, Some authors have confirmed a prevalence that varies between 7.2% and 40.3% in the Northeastern regions, 5.04% and 37.9% in the Southeastern regions, 1.28% and 27.1% in the Southern regions, and 6.3% and 16.75% in the Midwestern regions, numbers which warrant further study.³

It is well-known that there are differences in the prevalence of SAH within different populations, due to influences caused by biology, lifestyle, environment, organization of the health care system, as well as possible interactions among the components of these elements. This disease affects approximately 15-20% of the adult population, reaching 50% in the elderly population, and is most common in males between 45 and 50 years of age. After this age range, the prevalence is more common in women. SAH doubles the risk of cardiovascular disease, which is the primary risk factor for strokes.³

In Brazil, among the minimal strategic actions that could be identified in primary healthcare, which are the responsibility of local governments, is the control of high blood pressure, to be developed through the diagnosis of cases, the registration of SAH patients, and the control and treatment of blood pressure through educational actions.⁴

These actions, to be executed by the Family Health Strategy (FHS) and overseen by the Health Ministry, are geared toward the organization of primary healthcare services. Advice from the health surveillance of families and their surroundings aims to strengthen the ties between SAH patients and healthcare clinics. It should be emphasized that systematic and organized healthcare services should prevail over those of emergency healthcare.⁵

To accomplish this, assessing the performance of healthcare services is today of utmost importance for proposals that

seek to enhance the quality of these services by analyzing the attraction and coverage of the programmatic demand for high blood pressure treatment, the concentration of specific modalities of healthcare services, and the situation of the follow-up indicators of developed actions.⁶

Brazil, for more than two decades, has been undergoing expressive changes in the organization, financing, and supply of healthcare services, resulting mainly from the need to make basic, accessible, fair, and higher quality healthcare services available to the general population.⁴ From this viewpoint, the institutionalization of the FHS takes on a significant role as an instrument for the reorganization of the healthcare services system. This concept surpasses the old scheme, which was exclusively focused on the disease, and evolves through managerial and sanitary, democratic and participative practices, in the form of teamwork, geared toward the populations of specific areas, for which the teams assume full responsibility.^{5,6}

The training of these teams takes on an occupational profile that is distinctly traditional, which is more diversified professionally and, for this reason, can contribute to a better execution of the new model. This model is not geared toward exclusive attention for specific population groups, but rather focuses on the principle of health surveillance. One of its main characteristics is the interdisciplinary and multidisciplinary initiative, which must stimulate the mobilization of the community so that it can become responsible for the actions developed therein. The union between family and community represent the gateway for this type of program, which proposes to care for not only the disease, but also the population as a whole, taking into consideration the true needs of the community.⁶

This context has allowed for nursing to advance in both knowledge and actions, given the construction of an unparalleled space for nursing healthcare services, recognizing the nurses as fundamental and essential professionals in the execution and evolution of healthcare actions, which involve from direct interventions, in the doctor's examination and the prescription of medication, to indirect interventions, such as healthcare education for the general population.^{7,8}

Nevertheless, the role of nurses in the FHS has been facing difficulties and challenges, especially as regards nurses' activities, the distribution of responsibilities, working conditions, interdisciplinary relations, salary policies, access to qualification, and the lack of employment relations. In fact, nurses many times take on

responsibilities and duties that go beyond the resources available for their practice, accumulating tasks that interfere in the quality of service and in the development of activities.^{9,10}

This study, therefore, presupposes that nurses still face difficulties in prioritizing their activities and allot more time to administrative activities at the expense of healthcare services and educational activities.

Thus, it is valid to raise the following questions: How do the professionals within a family healthcare team perceive their own actions and those of the other members of the FHS, especially as regards primary healthcare services for SAH patients? And, more specifically, how is the role of the nurse perceived in this context?

The present study sheds light on a portion of the FHS primary healthcare services, through recorded interviews with the protagonists, that is, with the professionals that make up the family healthcare team in a specific city in the countryside of the state of São Paulo, regarding the actions developed to aid the SAH patient. Also highlighted in this work are the perceptions of these subjects concerning the nurses' role in programmatic activities.

MATERIALS AND METHODS

The present study is the result of a scientific initiative carried out voluntarily by undergraduate students in nursing from a private institution of higher education. This study is descriptive in nature and adopted the qualitative approach for data collection and analysis. The greater interest was to discover what the perceptions of the healthcare team are concerning each professional's own work as well as that of the other members in health surveillance actions for SAH patients. This study sought to motivate scientific thought through an in-depth study of an everyday problem by mapping, analyzing, and interpreting aspects linked to a given population.¹¹ From this point of view, to construct knowledge through empiricism, systematized stages are complied with in which psychosocial aspects of a defined group were given priority by means of a qualitative approach.¹²

The researchers limited this study to a family healthcare team from a city in the countryside of the state of São Paulo, considering the study's proposed aim and the complexity of the analysis of these data within a qualitative approach. This study invited six professionals, separately, who had worked together in the same family healthcare team for more than six months: a nurse, a general clinician, a nurse's aide, and three community health agents. The following acronyms were defined to represent the voices of the selected interviews: D for doctor, N for nurse, NA for nurse's aide, AG1 for community health agent 1, AG2 for community health agent 2, and AG3 for community health agent 3.

The location chosen to interview all participants was the family healthcare clinic itself, as it was deemed to be the most

reserved location possible. The interviews lasted an average of 30 minutes each and were all carried out on the same day, beginning at 1:00pm. All participants were quite collaborative and, although they were being recorded, presented no sign of uneasiness during the interviews.

The participants were asked to answer two questions: How would you describe the health surveillance actions for systemic arterial hypertension (SAH) patients performed by you or by your team? How do you perceive the role of the nurse in the team? The data were collected from September to October 2009.

The procedures followed ethical principles, as set forth by the National Health Board (NHB) in Resolution 196/96, and complied with the following stages: authorization from the chosen institution to perform the research, analysis and approval from the Research Ethics Committee (CAAE – 3470.0.000.251-09, protocol number 541/09), and collection of a signed written consent from all participants.

To analyze the obtained data, the interviews were transcribed, highlighting the most important parts. Next, the similar or completely distinct portions were selected.

This study opted to use the content analysis (CA) approach, which translates as a group of communication analysis techniques aimed at obtaining, through systematized and objective procedures, the description of the content of messages and indicators (qualitative or not) which allow for the inference of knowledge relevant to the conditions of production/reception of given messages. Among the various modalities of known CAs, the thematic analysis proved to be the most appropriate for this study, as it consists of the identification of nuclei of senses that are related to the behavioral characteristics or other relevant structures revealed in the discourse.¹²

Two thematic nuclei were produced in the present study: that which translated the significance of the speech and that which involved the study's proposed objectives, including intentions, actions, and limitations of the family healthcare team upon offering healthcare services to SAH patients, as well as the context of the nurses' activities.

The data were examined in light of prior assumptions from FHS and from findings in the literature.

RESULTS AND DISCUSSION

It is understood that multidisciplinary and interdisciplinary work in FHS for SAH patients aims to implement integrity within healthcare services in the sense of making more contextualized healthcare activities possible and produce better-quality solutions from the perspective of the co-responsibility of workers, users, and families. The actions taken must be equal for all in the planning and promotion of healthcare (educational activi-

ties related to changes in lifestyle, risk factors, and the production of educational materials); in the training of professionals; in referrals to other medical professionals, when necessary; in both individual and group healthcare services; in the participation in research projects; and in the management of the program. The FHS seeks to go beyond medical practices that are fragmented and strictly based on the cure, in which the concern over and the carrying out of procedures, the use of equipment, and the reproduction of pre-established norms are predominant, such as the healthcare services themselves, which many times does not serve the true needs of the families and users.^{13,14}

Considering the aforementioned assumptions, the participants' interviews were analyzed and discussed, highlighting the views that the professional regarding the work of the team in dealing with the healthcare provided to SAH patients and, more specifically, the role of the nurse.

ON THE INTENTIONS, ACTIONS, AND LIMITATIONS OF THE FAMILY HEALTHCARE TEAM IN HEALTHCARE SERVICES PROVIDED TO SAH PATIENTS

For the medical professionals, their interviews characterize the work load carried out by the team as involving taking blood pressure, doctor's appointments, and advice about medication, diet, physical activities, as well as the use of alcohol and tobacco. They assume the leadership role in activities when they give value to the clinical exams that are primarily performed in the doctor's office:

In addition to the doctor's examination and the request for exams, scans, all interrelated according to the secretary's protocol. And we are always asking for lipid and glucose functions, renal functions, urine exams from all high blood pressure patients. The advice about non-pharmacological measures do not change, physical activity, diet, less salt in food, reducing alcohol, we treat everything. Cutting down on smoking, and if possible, smoking habits as well as all of the comorbidities. Obesity, we advise physical activity together with weight loss, diabetes, etc. These are the more common actions taken in the doctor's office [...] (D).

It can be observed that the attention provided by this healthcare professional is exclusive to the interventions that treat the physiopathological questions of the physical body as defined by the healthcare program.

In this sense, the present study shows, within the subjectivity of the interview, that doctors' work is still distant from that of the healthcare team when they ignore the integration of the professionals in the formulation of shared intervention

strategies. It should be emphasized that their actions are limited to treating individual actions and ignore the importance of collective and personalized planning, even if the predetermined actions have been followed correctly.

The mentioning of the work performed by the nurse or the nurse's aide is made without distinction, decontextualized from the program. In other words, the healthcare service of the spontaneous request to check one's blood pressure is *done later*, referring to the receiving of healthcare services, but as an extension outside of the doctor's office, without citing the importance of the systematization and organization of the service: "We maintain a periodic control done later with nurse's aides and nurses, who regularly take the blood pressure of patients who arrive unexpectedly, in the reception area" (D).

It is understood that family healthcare is meant to go beyond mere hierarchical and technical labor in an attempt to work with social interactions among workers, with a greater horizontal structure and flexibility from the different powers, making it possible for greater autonomy and creativity of the agents as well as a greater integration within the team.^{14,15} However, when the doctor describes the team's and the community health workers' work, he/she generally uses the verb "help", attributing a quite limited role to this professional, referring to their work as mere helpers, as can be seen in the following statement:

Apart from the diagnosis and the measures that we take in the clinic, the rest is done by the nurses, the receptionists, and nurse's aides, as well as the advice given in the homes where community health agents help with the doctor's visits, advising the patient about the importance of the measures (D).

According to the doctors, they are responsible for treating the minor emergencies in their own clinics. Moreover, for more complicated cases, they refer the cases to tertiary healthcare services, as can be observed in the following:

We also refer patients, if they, in addition to hypertension, present some sort of complication in the target organ, we refer them to the tertiary clinic. We attend to minor hypertension emergencies here; we treat them with medication on the spot and try to control the problem (D).

The predominant biological character in the doctor's interviews confirmed that the traditional healing practices continue and hinder the possibility of reaching a work logic that gives value to the subjectivities and singularities of the subjects involved in the work process.

Findings from Krug et al.¹⁵ reveal difficulties in dialog and in the establishment of a common action plan. This healthcare

team was also segmented by professional nuclei, with a greater value attributed to the doctor, both on the part of the population, who make this request, and of the teams that are centered around the main reference of the doctor.

As regards the difficulties experienced in the reality of a healthcare clinic, the doctor raises two issues: the absence of specific work with children with high blood pressure, who go without specific treatment, and the difficulty in continuing educational activities for SAH patients.

It can be observed that some rather timid initiatives were taken to stimulate actions geared toward healthcare promotion and prevention, but these were not continued, possibly due to the lack of integration within the team, which can be seen in the excerpt below:

We have some groups that have dealt with this. A group of pregnant ladies, a group that began, but did not last long, but also involved taking blood pressure. A healthcare group in the square, we gathered all the students in the community, the doctors, and used to go there in the square to offer that battery of collective healthcare, check blood pressure, give advice, and distribute pamphlets. It's more an attempt to publicize the importance of high blood pressure in people's health (D).

The FHS is not geared toward the exclusive focus on specific population groups, but rather works with the principle of health surveillance, presenting the interdisciplinary and multidisciplinary initiative as one of its main characteristics. The teams that work in this program should strive to stimulate the organization of the community in an attempt to make them co-responsible for all actions developed therein.¹⁵

Interviews about the program, centered around the importance of the activities of these professionals who give value only to healing and welfare aspects, denounce the difficulty of teamwork, considered fundamental in family healthcare. The integration of the team was not mentioned, nor was the importance of the integrated actions of the professionals in the promotion of health and the quality of life of the SAH patient population.

This fact corroborates with findings from Kell and Shimizu¹⁶, in which the subjects of the FHS represent the work in teams as the union of the members in attaining a common goal. By contrast, the work process is fragmented and parceled, given that the activities are performed in an isolated or shared manner, but not interactive or integrated. The absence of the articulation of actions makes it difficult for the teams to find the space for healthcare service projects that attend to the broader needs of the family and the user.

In this same perspective, the community health agent reports that the monthly follow-up carried out with SAH patients is done mainly by these agents during their home visits:

The only action is this, the visits that the community health agents do monthly, trying to show them the importance of always checking their blood pressure, going to regular doctor's appointments, taking certain medicine, controlling one's diet, doing physical exercise. It's more us who speak to them monthly! (AG1).

The agents worry about the lack of SAH patients who join the therapy groups, but give value to the importance of this interaction.

They mention the existence of the dietary re-education group that, according to the interviewed agent, also aids in the follow-up of SAH patients, in addition to their own work, but that the work is still quite precarious:

We currently have a group. We really want to have groups. It was done at the beginning of the clinic; it was tried, but people didn't join. The same people always join and today we don't have any group for hypertension patients (AG1).

There is no group here in the clinic, no one is joining the group. The only thing that has a group, that they look for a bit more, that pulls them in, is the dietary re-education, to control their diet, and so they help us with that, but they don't tell them that there is only a group for this! (AG2).

The expression "do a promotion" is commonly used by these professionals when they speak of the advice that is given in the SAH patients' homes: "I, therefore, in my visits, try to do a promotion with the hypertension patients. Every three months, go to the doctor, do physical exercise, control your diet" (AG2).

Community health agents illustrate the importance of their work in their direct contact with people from the community during their home visits. They do not mention the work done by other professionals in the team or even the importance of the integrated actions for the enhancement of the quality of life of the SAH patient. The promotion is translated with information and advice about the control of risk factors for high blood pressure. In other words, the promotion of health is confused with prevention. What can also be perceived in this interview is the fragmented view of the agent, lacking the defense of the planned and systematized interventions. Their concern focused on individual care, outside of the community context, which was not mentioned in the interviews.

What makes the prevention different from the promotion of health is in the view of the concept of health itself. In prevention, health is simply seen as the absence of disease, while the promotion of health is taken on as a positive and multidimensional concept, resulting, in this manner, in a participatory model of healthcare, as opposed to the medical model of intervention.¹⁶

The family and the community represent the gateway to this type of program, which proposes to take care not only of the disease, but also of the population as a whole, taking into consideration the true needs of the community.¹⁵

The home visit (HV) is historically one of the basic tools of nursing intervention in caring for the families and the community. Its implementation began in primary healthcare with the implementation of the FHS. Healthcare professionals, including the community health agents, use a combination of knowledge and practice geared toward the prevention and promotion of health, through healthcare education. The HV affects people's daily routines, given that the understanding of conditioning factors of the health-disease process offers subsidies for the adoption of new healthcare habits and conducts. This study identifies the benefits of HV, such as the reduction in healthcare costs, the joining of individual and family, an open ear, the knowledge of the reality of people's lives, and the identification of risks within one's own home. However, it also highlights the difficulties, such as unprepared professionals, the inexistence of materials, the lack of time, and insufficient training.¹⁷

The agents emphasize the work performed in the HV and their own work:

The community health agent goes to the home, gets to know the family. We make the first contact to do their registration. We already discover the disease and whether or not they have hypertension, we check to see if they take medication, what the medications are, when their last doctor's appointment was, if they do physical exercise. The diet, we don't ask like How about your diet? We just ask: sausage, canned foods, bologna, these things, to get right to taking care of the people's high blood pressure (AG2).

For this professional, the work of the community health agents is essential for the diagnosis and follow-up of SAH patients:

We make the first contact to do their registration [...] We advise going to the clinic and setting up an appointment. They simply come here to set up an appointment, to get their diet right (AG1).

However, for the nurse's aide, the work with SAH patients all comes down to doctor's examinations and blood pressure monitoring in addition to the advice from community health agents:

I think that here in this clinic, at the moment, we have more doctor's appointments, and we monitor the blood pressure of these patients. Then there is the medical advice from the community health agents (NA).

Different from the other professionals, the nurse's aide does not report any work carried out with SAH patients. In addition, the nurse's aide was the only one that claimed her work to be relevant in the treatment of SAH patients.

The essentially technical and fragmented activities performed by the nurse's aide in the healthcare clinic with all of the users who seek healthcare services denote the distancing of the team and its lack of integration with the problems confronted by SAH patients, reinforcing the idea that personalized healthcare service is performed by the community health agents, while the technical procedures are performed by the nurse's aides and the doctors.

Santos and Matumoto¹³ illustrate that the connection and the care lead to an approximation of the professionals with the users, family, and community, by means of communication and the relationship established between them, which contributes to the work process of the team and brings benefits to the generation of healthcare. For the authors, dialog promotes the attempt to make it possible to resolve the demands conveyed by the users.

The present study treats the process of the unconscious and incorrect omission of the proper recognition of the nurse's aide's work in the dimensions of healthcare within the FHS, possibly historically constructed due to his/her technical education.

By contrast, the following nurse describes her work with SAH patients as follows:

We do blood pressure monitoring, which is something important, because it monitors people's blood pressure. This is not simply taking one's blood pressure. You give all of the medical advice, the use of medication, the correct use of medications, diet, physical activity, non-medicated treatments. You fill out the HIPERDIA [Enrollment and Monitoring Program for Hypertension and Diabetes Patients], which is also the moment at which you can give advice and make evaluations of the BMI, of the abdominal circumference, which are important things for us to think about in a metabolic syndrome (N).

It can be observed that this professional knows and recognizes the team's pre-determined activities and that these are relevant to the proper functioning of the program.

In contrast to the doctor, who places the community health agents as mere aides in home visits, the nurse recognizes this work as the first step for patients in this healthcare service:

There are the community health agents, who, in fact, are the first step in all this, who normally identify the people or why they claim to have some type of symptom. The agent refers the patient to us, where the diagnosis is made (N).

The following nurse questions the activities performed by the nursing department and questions those of doctor's examinations, which, apparently, is one frustration felt in the workplace: "In the medical advice, it is not only us who do the the blood pressure monitoring or fill out the HIPERDIA, these are other things that the nursing department does, but not us" (N).

For her, there is the doubt as to whether or not the activities performed by the nursing department are in fact pertinent to this professional. It can be inferred that these would represent medical interventions.

Although the technical attributions of each professional are defined, in a specific document of the FHS, drawn up by the Health Ministry, these attributions, which attempt to define a minimal profile of action, have not been sufficient enough to promote shared healthcare.^{9,10}

None of the interviewed professionals mentioned the holding of meetings to discuss the program and organize the work load. The concerns over the compliance of pre-determined activities are predominant in the interviews, at the expense of an integral healthcare service. Also observed was the distancing of the intentions from the actions, which serves to immobilize the team and their possible progress due to questions that have yet to be recognized or discussed by the group.

CONTEXTUALIZING THE NURSE'S ACTIONS

The reality of the nurses' work in the FHS does not always correspond to the foreseen attributions, and many times this professional ends up taking on responsibilities and functions that extend beyond resources available for their practice, in turn accumulating tasks that interfere in the quality of the service as well as in the development of activities.^{18,19}

This situation can also be observed in the present study. Doctors, nurse's aides, and community health agents, that is, all of the components of the team, report that the nurse is a professional that is highly present and participative. In the view of the interviewed team, the nurse performs many tasks within the program; however, nothing was mentioned in relation to their activities with SAH patients, which is different from the views of other nurses, as can be seen in the following interviews:

The nurse here at the clinic is a very nice person, she is always present [...] currently, the bureaucratic part has become quite heavy, so there has been no way to set up groups, but she attends to children as well, interspersed with the doctor, she collects cytologies [...] She's the supervisor of the nurse's aides. Of the community health agents. She is quite participative, makes home visits when requested by someone from the team [...] (AG1).

[...] she is now participating in the Tutorial Education Program (PET), which is a new program [...] she started to participate in the distribution and now this is a little more divided, more with the agents, but she is quite participative, not only within the team (AG2).

[...] she makes the first contact there with the pregnant woman, she does the family planning related to the woman and collects cytologies, [...] The Papanicolaou, blood pressure, glucose, takes care of the baby, childcare, the baby's first treatment, home visits as well (AG3).

The nurse ends up dealing with all of the administrative part, with the boss's part. She has her rounds that she does, the childcare, family planning, pre-natal, the pregnancy tests are also done by her. She ends up helping a lot at the reception desk, at the front door. All incidents that we have are reported to her (NA).

It is understood that family health is meant to surpass the mere hierarchical and technical work in an attempt to achieve social interaction among the workers, with a greater horizontal structure and flexibility of different powers, in turn generating more autonomy and creativity on the part of agents and greater integration within the team. This is one of the great challenges for the healthcare teams that have been inserted in family healthcare programs. If this integration does not occur, we run the risk of repeating the model of dehumanized and fragmented healthcare services, centered around the biological recovery of an individual and with a strict division of work and an unequal social value given to the wide range of duties. To construct a family healthcare project, it is necessary for the team to construct a common project. To achieve this, each professional's specialized work must run hand in hand with their colleagues. Moreover, the agents must construct a firm interaction among workers as well as between workers and users.^{19,20}

Although only the doctor and the nurse have referred to their work with SAH patients to report the duties of the nursing department (this not constituting a divergent point among the professionals), only the doctors and the nurses also raised the question of the non-implementation of specific nursing

healthcare services for SAH patients. The nurses also indicated that there is a systematization in this sense.

It could be observed that in the activities developed by the nurses, according to the nurses' interviews, the bureaucracy, the actions, and the developed program end up blocking them from carrying out activities geared toward SAH patients, according to that set forth by the Health Ministry.

We still haven't been able to implement it. We have a protocol ready, but setting it up here, some clinics have nurses do the doctor's evaluation of hypertension and diabetes patients (E).

She helps a lot at the reception desk as well. As regards the direct healthcare, the point is that it seems that she thinks about participating in the evaluations as well. However, the frequent follow-up of hypertension and diabetes patients has not begun yet. We've had this experience here, but in general know the importance. She is always participating and advising the personnel that come around here to take the patient's blood pressure (D).

It has been observed that nursing has evolved in its practice as well as in its achievements, as they can advise, request exams, and prescribe medication in public health programs, such as the FHS, which results in greater responsibilities, demanding a more adequate preparation on the part of the nurses to carry out their duties.¹⁰

By contrast, although the educational activities, for example, are an important part both of the nurses' activities and of the FHS, many of these practices are still geared toward the mere conveyance of knowledge and changes in habits and are far from being implemented as participatory methodologies understood as part of an educational process.¹⁸

Thus, historically, the healing, preventive, and administrative practices are still prevalent in the nursing profession and appear to be related to the activities that have been essentially developed by the nurses in the FHS.

It is evident that the FHS contributes to the enhancement of the community's access to basic healthcare services. In addition, the FHS has slowly modified this model by bringing the healthcare services to the population and introducing notions of prevention and promotion of family healthcare. It also seems to be indispensable to face the healthcare problems and their determining factors with actions that tackle the causes, such as the conditions of life, work, and leisure of the SAH patient. What becomes evident is the need to improve the practices relevant to the management of healthcare services on the part of all actors involved in the process – doctors, community health agents, nurse's aides, nurses, and users. This im-

provement consists of the ability to assess the problems found and promote the necessary resources in an attempt to ensure the integrity of healthcare services. This should be carried out through healthcare networks, respecting the interdependence among actors and organizations, since none of these possesses the totality of resources necessary for the resolution of problems from a given population.

We consider that the healthcare services clinic is not an isolated professional, but rather a team, in which the core focus is not exclusively individual, but rather the family and its surroundings. Moreover, the interventions necessary to promote healthcare must be sustained within the knowledge that contemplates the biopsychosocial determinations of health, disease, and care, as well as in the autonomy and making the professionals responsible for their users, families, and community. Furthermore, the healthcare services take on the core characteristic of a collective and complex work in which the interdisciplinary and multidisciplinary nature of the work becomes essential.^{9,14,20}

It is also important to note that, in this last interview from the doctor as regards the activities carried out by the nurse, there is once again the idea that the nurse helps because she has *experience*, and can participate in *the doctor's evaluations*, but *this still has not begun*. Here once again is the idea that the center of the team is the doctor, whose direct aid comes from the nurse, who is in turn aided by the nurse's aide; and, at the most distant point of the team, as a mere complement, are the community health agents.

Contrary to this view is that of the nurse, who makes it clear that the pathway to the patients who seek out these healthcare services is through the community healthcare agents, who, in their home visits, make the first contact with the families. In addition, the agents detect the need for referrals to specific services, providing the first medical advice for more in-depth healthcare services, which will be carried out by the healthcare team as a whole, without the centralization of knowledge, but rather in a shared effort.

FINAL CONSIDERATIONS

The FHS studied herein confronts challenges in the development of the primary healthcare services offered to SAH patients, as there is still no clear view on the part of each member of the team as regards the necessary work process to achieve fully integrated actions. The activities are fragmented and the importance of each professional in the chain of events is relative.

Some relatively timid initiatives can be observed in the search for actions geared toward the promotion and prevention of healthcare, but without continuity, most likely related to the lack of integration of the team with the work process, with a possible overload of activities in the daily routine of a basic healthcare clinic.

It could be observed that each professional presents a partial view both of the family healthcare program as well as of his/her own role within the scenario of the work in the team.

Specifically as regards the role of the nurses, it can be inferred that they face an overload of work and responsibilities within the FHS, with administrative tasks that hinder their work in educational activities geared toward the prevention of diseases. The reality of the work of the nurses in the FHS deviates from their predicted attributions, and many times they end up taking on responsibilities and functions that go beyond the resources available for their practice, accumulating duties that interfere in the quality of the service and in the development of activities.

Although the technical attributions of each professional are defined in the specific document of the FHS, as set forth by the Health Ministry, these attributions, which seek to define a minimal profile of their tasks, is not sufficient enough for work within a shared healthcare team. This difficulty seems to contribute greatly to hampering the nurses' daily routine, which ends up directing more time toward administrative activities at the expense of healthcare services and education.

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