

## Qualification of the family caregiver to the application of the Educational Technology in Health

*Capacitação do familiar cuidador com a aplicação da Tecnologia Educativa em Saúde*  
*Capacitación del familiar cuidador con la aplicación de la Tecnología Educativa en Salud*

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### How to cite this article:

Santos PDS, Santos ZMSA, Diógenes LMMB, Caldas JMP, Rodrigues KAF, Carneiro RF. Qualification of the family caregiver to the application of the Educational Technology in Health. Rev Bras Enferm [Internet]. 2018;71(3):1135-43. DOI: <http://dx.doi.org/10.1590/0034-7167-2017-0163>

Submission: 03-31-2017

Approval: 05-29-2017

### ABSTRACT

**Objective:** To evaluate the changes in the participation of the family caregiver in the treatment of the hypertensive person with the application of the Educational Technology in Health (ETH). **Method:** Participant research carried out in a Primary Health Care Unit with 11 family caregivers (FC). The ETH was elaborated based on health education and applied in ten meetings between June and August 2016. We organized the results into categories. **Results:** FCs experienced learning experiences through the exchange of information, socialization of experiences, and linkage establishments. The FCs were encouraged to share their doubts and experiences, so that, supported by listening to the professional, they felt welcomed and determined to fulfill their role with hypertensive relatives. **Final considerations:** The changes that have taken place have been highlighted in the learning of FCs and their commitment to family and self-care, as well as to the conviction that the family environment is indicated to make these changes effective.

**Descriptors:** Hypertension; Technology in Health; Health education; Caregiver; Nursing.

### RESUMO

**Objetivo:** Avaliar as mudanças na participação do familiar cuidador no tratamento da pessoa hipertensa com a aplicação da Tecnologia Educativa em Saúde (TES). **Método:** Pesquisa participante realizada em uma Unidade de Atenção Primária em Saúde com 11 familiares cuidadores (FC). A TES foi elaborada baseada na educação em saúde e aplicada em dez encontros entre junho e agosto de 2016. Organizamos os resultados em categorias. **Resultados:** Os FCs vivenciaram experiências de aprendizagem pela troca de informações, socialização de experiências, e estabelecimentos de vínculos. Os FCs eram incentivados a compartilhar suas dúvidas e suas experiências, de modo que, amparados pela escuta do profissional, eles se sentissem acolhidos e determinados a cumprir seu papel junto aos familiares hipertensos. **Considerações finais:** As mudanças ocorridas se destacaram na aprendizagem dos FCs e no compromisso destes com o familiar e com o autocuidado, bem como na convicção de que o ambiente familiar é indicado à efetivação dessas mudanças.

**Descritores:** Hipertensão; Tecnologia em Saúde; Educação em Saúde; Cuidador; Enfermagem.

### RESUMEN

**Objetivo:** Evaluar los cambios en la participación del familiar cuidador en el tratamiento de la persona hipertensa con la aplicación de la Tecnología Educativa en Salud (TES). **Método:** Encuesta participante realizada en una Unidad de Atención Primaria en Salud con 11 familiares cuidadores (FC). La TES ha sido elaborada basada en la educación en salud y aplicada en diez encuentros entre junio y agosto de 2016. Organizamos los resultados en categorías. **Resultados:** Los FCs vivenciaron experiencias de aprendizaje a cambio de informaciones, socialización de experiencias, y establecimientos de vínculos. Los FCs eran incentivados a compartir sus dudas y sus experiencias, de manera que, amparados por la escucha del profesional, ellos se

sintiesen acogidos y determinados a cumplir su papel junto a los familiares hipertensos. **Consideraciones finales:** Los cambios ocurridos se destacaron en el aprendizaje de los FCs y en el compromiso de estos con el familiar y con el autocuidado, así como en la convicción de que el ambiente familiar es indicado a la efectividad de esos cambios.

**Descriptores:** Hipertensión; Tecnología en Salud; Educación en Salud; Cuidador; Enfermería.

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## INTRODUCTION

Getting sick is a process that afflicts the being, which affects its biological, psychological, social behavior, and demands an increase in the care with its health<sup>(1)</sup>. When in chronic condition, the family is inserted into the care intensively, being essential in adherence and follow-up to treatment<sup>(2)</sup>.

Among the relatives, usually one and at most two stand out in the care with the others. Therefore, the family caregiver (FC) should be trained to perform the preventive actions and/or control of the diseases to the health of the member (s), especially when it is about chronicity. Thus, we agree with Soares et al<sup>(3)</sup> when they affirm that properly trained and adequately trained HR on systemic arterial hypertension (SAH) is a great facilitator of the treatment adherence process. Although the perception of the benefits of adopting measures for the prevention and control of hypertension does not necessarily imply the coherence and effectiveness of actions for adherence. Therefore, it is very important to provide the person with hypertension, elements so that she can understand the treatment leading her to believe that she will have positive results if followed suitably.

It is worth mentioning that the study by Santos<sup>(4)</sup> with 354 FCs of hypertensive individuals found that the majority had a deficit of knowledge about hypertension and treatment, despite showing significant involvement in the treatment of the hypertensive person. This fact is relevant, because the educational process starts from the rescue of the previous experience of the people, and from there in a dialogical relation, gradually begins the process of construction of new knowledge. In this context, we agree with Lopes and Tocantins<sup>(5)</sup> in declaring that health education (HE) enables the emancipation of the subject, and strengthens the link between democracy and education. Also, HE guides educational technologies.

In the area of health, we can define Technology, as an instrument for approaching users, enabling the sharing of knowledge about prevention, health promotion and rehabilitation of diseases<sup>(6)</sup>. The Educational Technology in Health (ETH) allows us to create and establish clear relationships between professionals health and users, aiming at the empowerment of this user in order to build their autonomy for self-care<sup>(7)</sup>.

In view of the fundamental importance of family participation in the treatment of hypertensive users and the lack of knowledge found in the previous study<sup>(4)</sup>, there is an urgent need to empower or empower FCs through HE actions in order to make their participation effective and efficient treatment of the hypertensive person, as well as to adopt preventive measures for the risk of hypertension among family members, since this is a hereditary condition.

## OBJECTIVE

Based on the relevant role of FC in the treatment of hypertensive users, we asked: *What does the familiar caregiver know about hypertension and treatment?; Can the Educational Technology in Health (ETH) facilitate the participation of the family caregiver in the treatment of the hypertensive person?* Through these questions, we opted for this study with the objective of evaluating the changes occurred in the participation of the caregiver notreatment of the hypertensive person with the application of the Educational Technology in Health.

## METHOD

### Ethical aspects

This study was developed in accordance with Resolution 466/12 of the National Commission of Ethics in Research (CONEP)<sup>(8)</sup>, which regulates research with human beings. Participants are guaranteed anonymity and the right to withdraw consent at any time they wish. We collected the data after signing the TCLE and issuing the favorable opinion of the Ethics Committee of the Universidade de Fortaleza - COÉTICA/UNIFOR. We identified the FCs by the letter E, followed by the numbering relative to the number of participants (E1 to E11).

### Type of study

It is a participant research. This research modality provides the researcher with the knowledge of the target reality, but also enables the integration, by means of a continuous action-reflection-action of the defined situation, by the awareness and understanding for decision-making, aiming at transformation<sup>(9)</sup>.

### ***Elaboration of the Educational Technology in Health (ETH) - Qualification of the Family Caregiver in the Participation of the Treatment of the Hypertensive Person***

We developed ETH based on the assumptions of Health Education. We opted for this theoretical-methodological reference, since we consider it of great relevance for the empowerment of FC in the decision making regarding the participation in the treatment of hypertensive people with a view to the prevention of complications and control of HAS. The ETH consisted of 11 weekly meetings, with an average duration of 60 minutes.

In the meetings we developed educational workshops through group dynamics, whose objective is to motivate and strengthen the affective bonds, thus favoring the collective construction of the knowledge about SAH and the treatment. We emphasize that the determination of the day of the week and time for the meetings were determined with the FCs, so

as not to hinder their daily routine. We conducted the field research in three stages, described below:

- *First stage*– Hypertensive people participated in a meeting held in consensus with the PHCU Coordination. The purpose of the meeting was to ask them to indicate a FC. Therefore, we invite the FCs to a meeting, in which the nature and purpose of the study were exposed; the registration of consent for participation in the study, through the signing of the Free and Clarified Consent Term (FCCT); and the appointment of the first interview, whose instrument contained socio-demographic and health data, as well as knowledge about hypertension and treatment. This phase ended with the opening of the first meeting for the application of ETH.
- *Second stage* - In this we apply the ETH, as follows:
  - First meeting: we rescued the experience of the FC in the participation of the hypertensive person to the treatment; Second meeting: we discuss the benefits of participating in the treatment and prevention of the risk of hypertension in other family members; Third meeting: we discussed about SAH, as a Public Health problem; and Fourth and fifth encounters: we discuss the SAH regarding chronicity, asymptatology, risk factors, diagnosis and risk/severity.
  - Between the sixth and tenth meetings we trained the FCs on the control behaviors of SAH and the preventive of the risk of SAH among the following family members - Sixth meeting: we planned a workshop with a Nutritionist about the importance of healthy eating. Seventh meeting: we organized a workshop with the physical educator, about the various alternatives for the fight against sedentarism, among them the regular practice of physical exercise. Eighth meeting: we invite a psychologist to schedule an interactive session on the prevention and combat of alcoholism, smoking and drug addiction. Ninth meeting: planning a momentum with the psychologist on stress management as one of the strategies for a healthy lifestyle. Tenth meeting: we addressed the importance of regular use of antihypertensive medication, as well as its storage, preservation, therapeutic and adverse effects, and discomforts.
  - Finally in the eleventh meeting we gave feedback on the participation of the FCs in the meetings and a self-evaluation of these. We then oriented the FCs in the elaboration of an "Action Plan" with a view to participating in the treatment of the hypertensive person and, finally, the second interview to be performed after 30 days of the last meeting was held.
- *Third stage*– In this we apply the second and last interview, whose instrument contained the guiding questions: Comment on their experience in these meetings with a view to their participation in the treatment of hypertensive person; Discuss the repercussion of these meetings with a view to their participation in the treatment of the hypertensive person; and How has your participation in the

treatment, after these meetings, been related to: yourself, the hypertensive family, and the other relatives?

## Methodological procedures

### Study scenario

The study was carried out in a Primary Health Care Unit (PHCU) of the Regional Executive Secretary VI (RES VI), in Fortaleza, Ceará, Brazil. The municipality of Fortaleza-CE is composed of seven Regional Executive Secretary (RES) - I, II, III, IV, V, VI and Center, in which the neighborhoods are grouped. RES VI includes 29 neighborhoods; is where the largest number of PHCU (22) is concentrated.

### Data source

Participating in the study were a group with 11 of the 15 FCs selected and indicated by the same number of hypertensive people enrolled in the PHCU, regardless of age, schooling, color, etc. Initially, we chose 25 FCs, taking into account the possibility of avoidance, since only 15 accepted to participate in the study, and 4 gave up in the first two meetings. We considered a group of 15 to 20 participants, adequate for this type of intervention. We call FC, that member of the family who stands out most in the care of the hypertensive person.

### Collection, organization and analysis of data

We performed the data collection from June to August 2016, through the techniques: interview and participant observation. The interviews were recorded according to the prior consent of the FCs, and the observations were recorded in the field diary. We organize the information from the content analysis, following the postulates of Bardin<sup>(10)</sup> according to the steps for the analysis and interpretation of the collected data: Pre-analysis, we carry out an exhaustive reading of the interviews and the observations recorded in the field diary; Exploration of the material after reading, identifying and constructing the categories and, later, we selected the excerpts from relevant testimonials; and Treatment of the results, with the results obtained, we organized in the categories and subcategories: sociodemographic and sanitary characterization of the familiar caregivers; and evaluation of the changes that occurred with the application of ETH - a description of the knowledge of family caregivers about systemic arterial hypertension and about treatment, experience during the application of Educational Technology in Health, repercussion of the application of Educational Technology in the participation of the familiar care, and description of the changes that occurred with the application of Educational Technology in relation to the family caregiver, the hypertensive user and other family members. We proceeded to the interpretation, based on the assumptions of health education, and in the selected literature.

## RESULTS

### Socio-demographic and health characterization of family caregivers

Among the FCs, 5 were in the age group of 31 to 59 years and the others between 60 and 73; 10 women and only one man,

the married, Catholic, natural of other municipalities of the State of Ceará stood out, individual monthly income of up to a minimum wage (MW) in force (R\$ 937.00) and family of up to two SMs; retirees followed by those engaged in household activities; Incomplete elementary education, own property, and nuclear family constellation. Nine FCs were hypertensive. Regarding the risk factors of hypertension, stress was predominant in ten FCs, family history of hypertension in nine, and use of animal fat and sedentary lifestyle in six.

### Evaluation of the changes that occurred with the application of Educational Technology in Health

This category comprises four subcategories: description of the knowledge of family caregivers about systemic arterial hypertension and about treatment; experience during the

application of Educational Technology in Health; repercussion of the application of the Educational Technology in Health in the participation of the familiar caregiver in the treatment of hypertensive users; and description of the changes that occurred with the application of Educational Technology in Health in relation to the family caregiver, the hypertensive person, and other family members.

### Description of knowledge of family caregivers about systemic arterial hypertension and over-treatment

Chart 2 shows that there was learning with the application of ETH, since the FCs revealed knowledge, mainly on the risk factors and risk/severity of hypertension, as well as on the therapeutic behaviors - adequate use of salt, use regular intake of the drug, and adequate coffee intake of 100ml/day.

**Chart 1 –** ETH - Educational Technology in Health-Training of the family caregiver in the participation in the treatment of the hypertensive person

Health Education Assumptions	Contents	Objectives	Strategies	Sources	Evaluation	Meetings
Recognition of knowledge built by experience	Previous experience of the family caregiver (FC) in the participation of hypertensive user adherence to treatment	Rescue FC experiences with a focus on SAH knowledge and treatment	Dynamics: 1) Interview 2) Knowledge balloons	Colorful balloons; Craft paper	Questions put to the group to rescue experiences	1 <sup>st</sup>
Valuing knowledge and aggregating new information	The family as it participates in the adherence of the hypertensive user to the treatment and the interface in the health promotion	To raise awareness of the benefits of participation in adherence to treatment and in the prevention of the risk of SAH in other family members	Dynamics: Bingo	Sulphite paper card (similar to bingo cards), pens, and prizes.	Awareness raising issues	2 <sup>nd</sup>
Contextualization of information	Systemic Arterial Hypertension (SAH) as a Public Health Problem	To discuss the problematic of SAH for Public Health	Conversation circle	Chairs in the meeting room	Awareness raising issues	3 <sup>rd</sup>
Expansion of new information	SAH - concept, chronicity, asymptatology, risk factors, complications and risk/severity.	To raise awareness on the SAH on the aspects: chronicity, asymptatology, risk factors, diagnosis, etc.	Dynamics: Building Concepts	Cardboards, crepe tape, stereo	Questions put to the group to rescue experiences	4 <sup>th</sup> 5 <sup>th</sup>
Empowerment through empowerment and awareness	SAH control lines 1) healthy eating; 2) regular physical exercise; 3) abstaining from addictions: alcoholism, smoking and other drugs; 4) Stress management; 5) Regular use of the drug	To train the FC on the conducts of control of SAH and the preventive of the risk of SAH among the other members of the family	1) Workshop with Nutritionist; 2) Workshop with Physical Educator; 3) Conversation with the Dynamic Psychologist: Telegram; 4) Psychologist Life-Mantle of personal power; 5) Dynamic Nurse: The Cabbage	Rectangular white satin cloth, paper craft, stereo;  Other resources depending on the professional	Feedback through group questions.  Awareness raising issues	6 <sup>th</sup> 7 <sup>th</sup> 8 <sup>th</sup> 9 <sup>th</sup> 10 <sup>th</sup>
Evaluation and self-assessment of attitudinal changes	Action Plan for participation in hypertensive user adherence to treatment.	Draw up an Action Plan with a view to participation in the adherence of hypertensive users to treatment.	Dynamics: 1) Crumpled Paper; 2) Brainstorming	Papercrafts; Stereo	Feedback through group questions and self-evaluation dynamics	11 <sup>th</sup>

Note: SAH - Systemic Arterial Hypertension; FC - family caregiver



**Chart 2 – Knowledge of the Family Caregiver on Systemic Arterial Hypertension and treatment with the application of Educational Technology in Health, Fortaleza, Ceará State, Brazil, 2016**

Interviews Knowledge	1 <sup>st</sup>		2 <sup>nd</sup>	
	Yes	No	Yes	No
<b>SAH</b>				
Concept	01	10	04	07
Way of discovering	--	11	--	11
Risk factors	02	09	11	--
Assymptomology	--	11	--	11
Inability of healing	04	07	09	02
Risk/Severity	03	08	11	--
<b>Treatment</b>				
Regular use of salt	08	03	11	--
Use of vegetable fat	04	07	08	03
Alcohol abstention	08	03	08	03
Tobacco abstention	05	06	09	02
Use of artificial sweetener	02	09	05	06
Regular use of medicine	11	--	11	--
Regular physical exercises <sup>1</sup>	02	09	07	04
Proper coffee ingestion <sup>2</sup>	01	10	--	11
Prevalence of vegetables <sup>3</sup>	03	08	09	02
Prevalence of white meat <sup>4</sup>	04	07	07	04
Stress management	03	08	10	01
Therapeutic scheme				
Medicine name	08	03	10	01
Daily concentration	03	08	06	05
Nº of doses/day	08	03	10	01
Therapeutic effect	02	09	05	06
Side effect (s)	--	11	04	07

Note: SAH – Systemic Arterial Hypertension; <sup>1</sup>Notice 03 times a week; <sup>2</sup>At 100ml a day; <sup>3</sup>Vegetables in the main meals, fruits in the snacks and dessert; <sup>4</sup>from 04 times a week.

### Experience lived during the application of Educational Technology in Health

FCs have experienced learning experiences mediated through information exchange, dialogue, socialization of experiences, clarification of doubts and linkage establishments.

*[...] I do not know much. We talked about high blood pressure. He talked about so many things. It was not just the doctor [nurse] talking, we also talked [...]. (E1, 72 years)*

*[...] the group here was good, there are other people who have high blood pressure also equidate, just like me. It is so much to learn, right [...]. (E2, 61 years)*

The realization of groups created an affective relationship between the participants.

*[...] had the jokes here with us, then we had to talk, but I liked it. The doctor had to know what we were learning too, right. Here in the meetings the staff took the doubts, sometimes the health center is not like that, I'm not much to ask, but the health center is more crowded, there are more people [...]. (E2, 61 years)*

*[...] when you start looking after someone, you have to know a little bit about the disease. When I can accompany him in the consultations, I always remember the day that is for him not to miss [...] so the group was good, so that we talk about what he knows and what he does not know, he learns.[...] (E7, 69 years)*

We noticed in the report of FC, the commitment to seek knowledge to provide quality care to the hypertensive person.

### Repercussion of the application of Educational Technology in Health in the participation of the familiar caregiver

Through their experience in the group, FCs were encouraged to share their doubts and experiences, to socialize knowledge, so that, supported by listening to the professional, they felt welcomed and determined to fulfill their role more efficiently with their hypertensive relatives.

*[...] the doctor talked a lot about high blood pressure [...] there's something I do not remember anymore, but I'm taking more care and fighting with her [sister] to take care of her too. People when they learn something new and see the person doing wrong, want to fight soon. I told her not to eat salty food that is very bad [...]. (E2, 61 years)*

The difficulties are transposed, when a comfortable and friendly relationship is promoted. The properly trained FC becomes a health promoter, as well as a partner of fundamental importance in the treatment of the hypertensive person.

*[...] at the health center we do not have time to clear all doubts, so it was so important these meetings. If you want to take care you have to understand the disease, you have to bring doubts, seek to learn. It would be important to have this, because in the health center they help, but it is crowded, not only people with high blood pressure, there are children, people to consult with so many other diseases [...]. (E5, 38 years)*

One of the favorable points in the realization of groups is listening to the FCs, when there is room for dialogue, these being not just people who receive information. Horizontality is perceived in the dialogue, allowing the participation of all involved and, especially, mutuality in the learning process.

*[...] with the meetings we become more aware of what happens when the person has high blood pressure, what he can feel, what he can have, what he can not do and what he must do to get well with the good pressure. It was good because of this, because if we learn, there is something that I have not learned well, because it is a lot to know, but we can help more and not only say that it takes care [...]. (E9, 43 years)*

Being aware of what one wants to take care of is important in identifying and preventing the complications of the disease.

### **Description of the changes that occurred with the application of Educational Technology in relation to the family caregiver, the hypertensive person and other relatives**

#### **Family caregiver**

The changes that took place were highlighted in the learning and commitment of FC with self-care.

*[...] I did not learn everything, I'm not even going to lie, but I already told them some things that I learned from high blood pressure, it was good if I had more at the health center, right?(E1, 72 years)*

In this report, we perceive the desire of the FC in the offering of these educational actions by PHCU.

*[...] I enjoyed participating, we learn, right [...] there is a lot. We had the freedom to talk, people asked, this is good, because there are moments that we do not know anything about the pressure. I asked a lot, on the medicines [...] gave everyone else something to learn [...] we knew more of the pressure to help, when you do not know, wrong help. So I liked it. I liked to have participated, so I had not come any more [...]. (E3, 52 years)*

*[...] I now see if she has any reaction from the medicine she takes[...] and I'm up for it to take and not forget, and also not to eat everything she wants [...].(E3, 52 years)*

Knowledgeable FC is a home health promoter, who passes on the information to other family members, reducing the burden and promoting self-care of the hypertensive user.

#### **Hypertensive person**

*[...] I've been learning about the medication, I'll even ask her [sister] if she feels anything, she never told me anything, but she's going to feel it and does not even know what it is [...] pressure medication [...] had some people here from the group who said they feel [...]. (E1, 72 years old)*

Although not aware of the dosage of the medication, its therapeutic and adverse effects, the FCs recognized the importance of adherence to the treatment.

*[...] when I got home I would always tell my sister what had been said here, because there was something I did not even know [...] how I have high blood pressure, I also take care of myself and help her to take care [...] we saw that it was doing right [...]. (E2, 61 years)*

*[...] what I learned here and I learn at the health center serves for me that I am sick and I try to take care of, so I try to help and say what I learn for her [...]. (E9, 43 years)*

There is an inadequate or non-existent health education strategies for FCs within the activities developed by EqSF (Family Health Teams).

#### **Other family members**

*[...] I learned some things for myself and I spoke to others in my family and my neighbor because it is very important to know the risks of high blood pressure [...] there is something I did not know, I just kept looking and listening [...]. (E2, 61 years)*

*[...] with everything that was said here, I was already going to her [mother], and for my husband, they liked it very much and said that it was not for me to stop coming ... we learn more and can help better [...]. (E5, 38 years)*

When FC assumes the role of caring, it receives no training to develop daily skills, especially when there is a dependency and insufficient knowledge.

*[...] at home the person who makes the food is my daughter [...] only when she goes to meet someone [manicure] do the food [...] I always tell my children to eat healthy, and with greenery. Children do not like food without salt, but they have to eat, because it is to do no harm to health and pressure [...]. (E6, 71 years)*

Knowledge about risk factors is relevant for the prevention of hypertension.

*[...] here we learn about high blood pressure and this is good for our life [...] me, as a person who has the disease and for the mother who takes care of her with the same disease, I say to my children to take care of themselves. They were meetings that we learned and that we teach to those who did not come and did not participate in caring to avoid having high blood pressure [...]. (E9, 43 years)*

## **DISCUSSION**

As for age, there were very significant divergences, in which we observed both adult and elderly FCs. For Nascimento et al<sup>(11)</sup> care starts from the moment that the relatives institute their actions to the entity that needs care accepting aspects of care, thus becoming caregivers.

Faria et al<sup>(12)</sup> report that the low socioeconomic status reflects in the non-adherence to the treatment of SAH. Unfavorable socioeconomic conditions make it difficult to acquire medication when necessary and less access to healthy food. These conditions are congruent with FCs, which in a way may affect their health, since there were, among them, cases of SAH and risk factors for SAH. For Oliveira et al<sup>(13)</sup>, the risk factors for hypertension are related to age, ethnicity, ethnicity, sex, obesity, inadequate salt intake, smoking, socioeconomic and genetic factors. Discerns about risk factors have a positive influence on the prevention of SAH complications, since the identification of these factors makes it possible to perform actions in order to minimize them<sup>(14)</sup>.

According to Ramos et al<sup>(15)</sup>, schooling is a determining factor for treatment, since low schooling represents a difficulty to follow and read the medical prescription, to distinguish the various medications used and to recognize their therapeutic

and adverse effects, a fact that corroborates the during the application of the ETH.

Flich et al<sup>(16)</sup> focus on the link, approaching and accomplishing the exchange of information between the health professional and the participating members as the central point of the HE, so that the expected outcome is the achievement of effective educational practices. Speech and listening are relevant because they encourage participation and, consequently, lead to learning.

In his study, Melo<sup>(17)</sup> observed the mesh of relations and forces observed in the group. Thus, the social use that members make of groups is supported in a relationship that produces bonds of trust among those involved. In the FC group, bonding was the heart of learning in view of the results achieved with ETH.

According to Melo<sup>(17)</sup>, group participation in SAH allows the learning of creative and original action, which will reflect in the uses to which the members of the groups plan their actions in order to overcome the bureaucracies imposed by the health services. The group is important because people feel at ease to answer their questions about SAH and its treatment, and because of the high demand observed in the PHCU, they have the time for more limited care. Lima et al<sup>(18)</sup> point out that the link between the user and the health unit is based on the way the professionals treat it, from opening to dialogue within and outside the consultation space.

In the study by Baltor et al<sup>(19)</sup>, the caregiver understands that health professionals see the family as the main executor of the necessary care to a sick entity. Thus, the family is responsible for the faithful execution of what is prescribed by the professionals.

Therefore, the family should be able to provide care, in addition to receiving social support, if appropriate. García et al<sup>(20)</sup> report the importance of attention to FC in assuming such a commitment, as they face some difficulties during the care process, which are characterized, mainly, by moments of stress.

For Meneses Junior et al<sup>(21)</sup>, the educational practices carried out at PHCU are still based on a hegemonic HE model, in which there is little or no participation of users.

García et al<sup>(20)</sup> point out the importance of listening, the exchange of information between FC and health professional for the development of sensitive educative practices, in order to promote a relationship of trust, providing the link and interaction.

When the family member assumes the role of caregiver in the home, he often feels the sense of unpair, which brings with it a need for information and guidance from health professionals to continue treatment<sup>(20)</sup>.

In Primary Health Care (PHC), the educational activities developed by health professionals aim at empowerment to obtain adequate health conditions, which in this process is indispensable to community interaction aiming at a critical reflection of their needs and essential changes for a lifetime healthier<sup>(22)</sup>.

Castro et al<sup>(23)</sup> stated that it is important for FC to intervene in the sick family member, such as the understanding of these interventions for their own self-care, especially for people who are already vulnerable to developing a chronic disease or, as in the case above, for those who are already sick.

Paiva et al<sup>(24)</sup> certify the need to devise education strategies, turning their main objective towards individual and collective

empowerment, strengthening the relationship of social support. Sá et al<sup>(25)</sup> highlight the importance of identifying the learning preferences of FCs, since each one presents a different cognitive level, so it is up to the professionals to know the FCs and, from there, to elaborate the educational interventions that aim at the best learning in accordance with the clientele.

FC empowerment is an important support for health professionals, since they can monitor the plan of care, be alert to complications related to chronic diseases, offer psychological support and follow up in routine consultations<sup>(26)</sup>.

Loureiro and Fernandes<sup>(27)</sup> highlight the importance of using dialogue with educational information among health professionals and family caregivers as a necessary support for quality care and maintenance of the caregiver's own well-being.

ES as a learning process develops the perception of the hypertensive person to the primary prevention of the disease, but also becomes relevant for the recognition of situations that determine/generate complications or even impairment of quality of life<sup>(28)</sup>. Floriano et al<sup>(29)</sup> point out the need for professionals to be closer to the FCs, directing and accompanying the care, aiming at the expanded assistance. The regular participation in the meetings emphasizes the interest of learning about what we want to take care of efficiently and effectively.

In the traditional model of health education, we notice the presence of an action of a merely informative nature, that is, a monologue in the professional-user relationship, in which the professional is a transmitter of information and the user an inactive receptacle of everything content. The client becomes a deposit of disjointed information of his subjective needs verbalized by the educator<sup>(21)</sup>.

### Study limitations

This study has limitations on the number of participants, because it was very difficult to locate and gather these people and even to approach them and obtain their consent regarding participation in the study, both for the unavailability of time and for professional commitments. Therefore, the final considerations and recommendations presented cannot be generalized. However, this study allows the realization of others on the same theme.

### Contributions to the area of Nursing, health or public policy

The contributions of this study to the area of nursing, health or public policy, are inserted in the epidemiological context of a country that is in an accelerated process of aging, whose consequence will be the increase in the prevalence of chronic diseases, which in turn, will be able to gradually evolve dependency on care of others. Among these, the most prevalent is Systemic Arterial Hypertension (SAH). Regardless of this fact, family members should be trained to be caregivers, contributing to the early de-hospitalization of people who need care in short, medium or long term care.

### FINAL CONSIDERATIONS

The results allow us to admit that there was learning among the FCs with the application of ETH. Of course, unequally,

each FC informed different experiences in the care process. However, the lack of prior knowledge about SAH and treatment differed between them. The mode of participation of the FC was revealed by the collaboration, integration and solidarity between the members of the family; by acting as a multiplying agent of educational guidelines on the control of hypertension and in monitoring the conduct of control of this condition.

Participation in the ETH led the FCs to experience learning experiences mediated by the exchange of information, dialogue, socialization of experiences, clarification of doubts and links establishments; generated changes in their lifestyle, with

adoption of healthy habits, commitment to the person cared for and self-care; has formed the conviction that the family environment is suitable for the implementation of these changes.

The educational process during the application of the ETH was laborious due to the low schooling of the FCs. On the other hand, it was offset by the involvement and enthusiasm of these participants in the performance of the ETH. The results of the study could enable (re) planning of health education strategies by the Family Health Team with the FCs in order to empower them for the participation in the treatment of hypertensive people, contributing to the promotion of the health and well-being of these and the FCs.

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