

PARTICIPATORY DIAGNOSIS OF HYPERTENSIVE PATIENTS IN THE FAMILY HEALTH STRATEGY: EXPERIENCE REPORT IN THE TERRITORY OF EUNÁPOLIS, BRAZIL

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Abstract: This article presents an experience report derived from a university outreach project linked to the Medical School of Faculdade Pitágoras de Eunápolis, aiming to strengthen primary health care through the analysis of the profile of hypertensive patients enrolled in the Moisés Reis Basic Health Unit,

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located in the municipality of Eunápolis, Bahia, Brazil. The initiative involved territorial mapping of a micro-area, home visits, educational dialogue, and the application of a semi-structured questionnaire addressing lifestyle habits, clinical aspects, and treatment adherence. The methodology adopted was quantitative-descriptive, without any interventional or invasive procedures, in full respect of ethical principles and local health realities. The findings revealed a predominance of women over 50 years of age, high adherence to antihypertensive medication, regular engagement in leisure activities, and low incidence of smoking and alcohol consumption. However, many participants presented altered blood pressure levels and symptoms associated with hypertension. The experience highlighted the positive impact of educational actions and active listening on users' awareness of their own health conditions. The project reinforces the transformative role of university outreach in medical education by integrating scientific knowledge with social commitment and generating relevant data for public health planning.

Keywords: Hypertension; university outreach; primary health care; epidemiological profile; lifestyle habits.

INTRODUCTION

Systemic arterial hypertension (SAH) is one of the main public health problems in Brazil and worldwide, characterized by its high prevalence, multiple causes, and strong association with severe clinical outcomes, such as acute myocardial infarction, stroke, and chronic renal failure. According to the Ministry of Health (2023), approximately 27.9% of the Brazilian adult population is hypertensive, with a higher incidence among women and the elderly. In Bahia, this prevalence follows the national average, being observed especially in communities with low income, limited access to health services, and a high rate of sedentary lifestyle and poor diet (SESAB, 2023). These data highlight the need for territorialized surveillance and intervention strategies, especially in the context of primary care.

The Family Health Strategy (FHS), a central component of Primary Care of the Unified



Health System (SUS), aims to promote comprehensive and continuous care for the enrolled population, acting on the social determinants of health and prioritizing prevention and promotion actions. In the context of arterial hypertension, the FHS plays a decisive role, as it enables the continuous monitoring of cases, guidance on healthy habits and the strengthening of the bond between professionals and users. However, despite the recommended structure, there are still significant gaps in the precise identification of local epidemiological profiles and in the development of personalized care actions, especially in peripheral and vulnerable communities.

Hypertension is a multifactorial chronic disease, whose etiology involves the interaction between genetic, environmental, physiological, and behavioral factors (Porto, 2019; Brazilian Society of Cardiology, 2020). Studies such as those by Sanjuliani (2002) and Brasileiro Filho (2021) point out that advancing age, the presence of comorbidities such as diabetes mellitus, chronic stress, poor diet, smoking, excessive alcohol consumption, and physical inactivity are determining factors for the development and worsening of SAH. In this sense, the understanding of the profile of hypertensive patients in a given territory must go beyond biomedical aspects and also consider the social and cultural determinants that structure the health-disease process.

In the Moisés Reis neighborhood, located in the urban area of the municipality of Eunápolis-BA, there is a population with markedly heterogeneous characteristics, whose living conditions directly influence the patterns of illness. The absence of updated and systematized data on hypertensive patients in the region motivated the elaboration of this extension project, with the objective of carrying out a participatory diagnosis with users registered in the local Basic Health Unit (UBS). The action was based on home visits, territorialization of the micro-area and active listening to the subjects, respecting their experiences and singularities, in order to subsidize professional practice with empirical data and contribute to the development of more effective care strategies.

The central problematization that guided the experience lies in the disconnection between the official notification data and the reality experienced by hypertensive users in the community. In many cases, there is low adherence to treatment, incorrect use of medication, lack of knowledge about



adverse effects, and lifestyle habits that are not compatible with adequate blood pressure control, even in the face of free access to health services. Such a scenario suggests the existence of not only structural, but also communicational and educational barriers, which compromise the clinical management and autonomy of patients. In view of this, it is urgent to investigate how these subjects experience the hypertensive condition and how their daily practices interfere in the effectiveness of public health policies.

The theoretical basis that underlies this experience includes classic and contemporary authors on hypertension, public policies, health promotion and care practices. Sanjuliani (2002), Porto (2019) and Antczak (2005) contribute to the clinical, pathophysiological and classificatory definition of SAH, while Loyola and Jardim (2018) and Leinig (2023) discuss the relationship between diet, obesity and blood pressure. In the psychosocial dimension, studies such as those by Aparecido (2014) and Paredes and Ribeiro (2014) highlight the influence of stress, job insecurity, and socioeconomic inequalities on the worsening of the disease. These authors are fundamental to understand the complexity of health care in the daily routine of basic units.

In addition, scientific production on quality of life and adherence to treatment has pointed out that coping with SAH requires interdisciplinary approaches and subject-centered strategies. Authors such as Hanus et al. (2015) and Cha et al. (2012) indicate that sleep disorders, cognitive dysfunctions, mood disorders, and difficulties in sexual life are often associated with uncontrolled blood pressure. Such manifestations, often neglected in clinical consultations, emerge strongly in participatory approaches such as the one carried out in this project. The use of semi-structured questionnaires allowed these dimensions to be captured in a sensitive way, bringing the scientific view closer to the reality experienced by the patients.

Another central point in the study's rationale is the territorialized approach to health, defended by Bissacotti et al. (2019), who consider territorialization an indispensable instrument for the planning of public health actions. The construction of bonds during home visits and the recognition of the territory as a living space of care enabled the development of qualified listening and



the collection of consistent data. This allowed not only to describe the sociodemographic and clinical profile of hypertensive patients, but also to identify gaps in health education, daily habits, and users' understanding of their own diagnosis.

Thus, this article aims to report the experience of participatory diagnosis of the profile of hypertensive patients followed by the Family Health Strategy at the UBS Moisés Reis, highlighting the relevant findings on lifestyle habits, associated symptoms, use of medications and perception of one's own health condition. It seeks, with this, to contribute to the strengthening of comprehensive care practices in primary care, in addition to reinforcing the importance of university extension as a formative space and transformer of social reality.

Finally, it is understood that the construction of this knowledge, based on systematic observation and the active participation of the subjects, expands the role of the public university in the production of contextualized solutions to the challenges faced by the SUS. The articulation between theory and practice, between science and community, between teaching and care, reveals itself as a possible and necessary path for the consolidation of a more humanized, critical medicine committed to the social determinants of health.

METHODOLOGY

This is an experience report study, with a quantitative-descriptive approach, based on the activities developed by students of the Medicine course at Faculdade Pitágoras de Eunápolis, within the scope of a university extension project linked to the CETSC and PINESC axes. The main purpose of the action was the critical and humanized training of future health professionals, based on direct contact with the local reality and the participatory analysis of the profile of hypertensive individuals enrolled in the Family Health Strategy (ESF) at the Moisés Reis Basic Health Unit, located in the municipality of Eunápolis, in the extreme south of Bahia.

The experience took place during the second half of 2024, with the micro-area corresponding



to Avenida Domingos Reis, a territory attached to the UBS Moisés Reis, where home visits, educational activities and the application of collection instruments were carried out. The location was chosen due to the significant presence of hypertensive patients, previously mapped in partnership with community health agents and professionals from the unit itself, based on the registration of the Primary Care Information System (SIAB).

The sample consisted of 13 hypertensive individuals, out of the 19 initially identified and invited to participate, resulting in an adherence rate of 68.42%. All participants were registered at the UBS and voluntarily agreed to contribute to the project. It should be noted that, as this is a report of academic experience in extension, there was no invasive collection of sensitive data or therapeutic intervention, only observation and educational record, which is in line with the formative practices guided by the National Curriculum Guidelines of the Medicine course, which encourage teaching-service-community integration.

The instrument used for data collection was a semi-structured questionnaire, with open and closed questions, adapted from the model validated by Gusmão and Pierin (2009), originally aimed at assessing the quality of life in hypertensive patients. The version used was reformulated by the students and professors to meet the objectives of the project, maintaining 35 questions pertinent to the clinical, physiological, socioeconomic and behavioral dimensions of the participants. The application of the instrument was carried out in person, in a home environment, with respectful reception and active listening, prioritizing accessible language and the bond between the academic team and the community.

In addition to the questionnaire, observational records were made during the visits, including voluntary blood pressure measurement in nine of the thirteen participants, using a calibrated sphygmomanometer and stethoscope. The measurement followed the clinical protocols recommended by the Brazilian Society of Cardiology (2020), and had a formative character, being conducted under faculty supervision. The experience was enriched by an educational dynamic with the use of colored stickers (red, blue and yellow), developed as a strategy to help elderly and illiterate patients in the



organization of medication and times of use, promoting greater therapeutic adherence.

Regarding the ethical aspects, although this is not a research with clinical or risk implications, the principles of Resolution No. 510/2016 of the National Health Council were followed. All participants were informed about the objectives of the project, about the educational nature of the activity and about the non-obligation to answer the questions or allow blood pressure to be measured. A Free and Informed Consent Form (ICF) was obtained in a physical form, signed by the participants themselves or their legal guardians. The data collected were kept confidential, stored in a safe place, under the responsibility of the teaching team, and will be used exclusively for academic and scientific purposes, respecting the anonymity and confidentiality of the information.

The methodological proposal, centered on extension practice and participant observation, sought to integrate theoretical knowledge about arterial hypertension with the reality experienced by primary care users, allowing students to critically understand the social determinants of health, barriers to care and the importance of qualified listening. It is, therefore, a training process that values the ethical, political and human dimension of medical education, while contributing to local health planning.

DISCUSSION AND ANALYSIS OF RESULTS

The demographic composition of the sample group revealed a predominance of females (69.23%), with all women over 50 years of age. This finding confirms the trend described by Brasileiro Filho (2021), according to which the prevalence of hypertension is more pronounced among adult women, especially after menopause, when there is a sharp drop in estrogen levels and consequent loss of vascular protection. The literature also points out that vascular aging, characterized by reduced arterial compliance and increased peripheral resistance, is a determining factor for blood pressure elevation, especially in postmenopausal women (Porto, 2019; Sanjuliani, 2002).

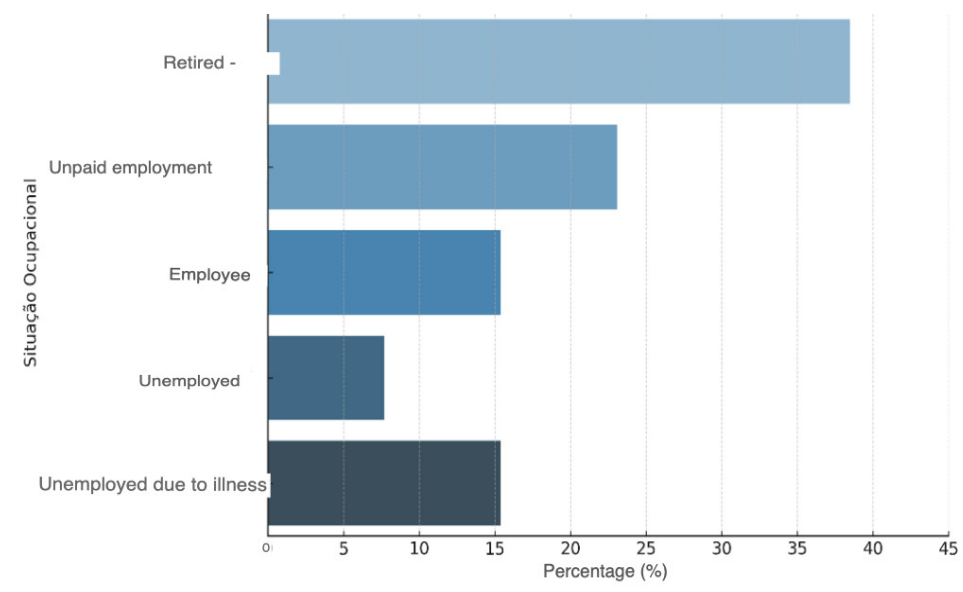
The average age of the participating men was even higher (72.75 years), which corroborates



data from the Brazilian Society of Cardiology (2020) on hypertension as a condition that accompanies advancing age. In this context, the findings of the present study indicate that the hypertensive population cared for by the Moisés Reis UBS has an age profile that requires increased attention, considering the risk of comorbidities and clinical complications common in the elderly. This finding reinforces the importance of longitudinal care and constant blood pressure surveillance as a strategy for disease prevention.

The occupational situation of the participants showed a contingent mostly made up of retirees (38.46%), followed by people with unpaid employment (23.07%) and individuals on sick leave (15.38%). Such socioeconomic configuration indicates financial fragility and high dependence on the public health system. According to Aparecido (2014), arterial hypertension is closely associated with the socioeconomic position of the subjects, being more prevalent in low-income populations, with limited access to resources that favor healthy lifestyle habits. These data were visibly represented in Graph 1 – Occupational situation of the sample group, to be inserted in this section.

Graph 1 – Occupational situation of the sample group



Source: Field research, 2024.



Although the social determinants of health are widely recognized as conditioning factors of hypertension, it is observed that the impact of these conditions on adherence to treatment and quality of life is still underestimated in primary care services. Paredes and Ribeiro (2014) highlight that chronic stress associated with economic instability, precarious retirements, and informal jobs contributes to the increase in blood pressure levels, generating cycles of progressive illness. The absence of integrated actions between the health sector and social assistance therefore compromises the effectiveness of care.

The age and occupational distribution of the group studied suggests that hypertension manifests itself in a context of multiple vulnerabilities, which reinforces the need for intersectoral approaches. The articulation of the FHS with the equipment of the social assistance network, such as the CRAS and the living services for the elderly, can expand the capacity to cope with risk factors and favor the construction of unique therapeutic projects. The experience lived by the academic team during the extension project allowed the direct observation of this complexity and signaled the importance of territorialization as a care management tool, as recommended by Bissacotti et al. (2019).

The survey of the participants' lifestyle habits revealed significant data regarding the prevention and control of arterial hypertension. Of the thirteen individuals interviewed, 84.62% stated that they did not use alcoholic beverages or tobacco. This information is consistent with clinical guidelines that point to alcoholism and smoking as aggravating factors for hypertensive conditions. According to Souza (2015), cigarette use directly interferes with blood pressure levels, increasing heart rate and vascular resistance, while alcohol, even in moderate doses, can reduce the effectiveness of antihypertensive medications, as described by Klatsky (2015).

The low incidence of smoking and alcohol consumption in the sample can be interpreted as a protective factor, but it is necessary to consider the possibility of underreporting due to social embarrassment at the time of the household interview. Even so, the predominance of abstaining habits



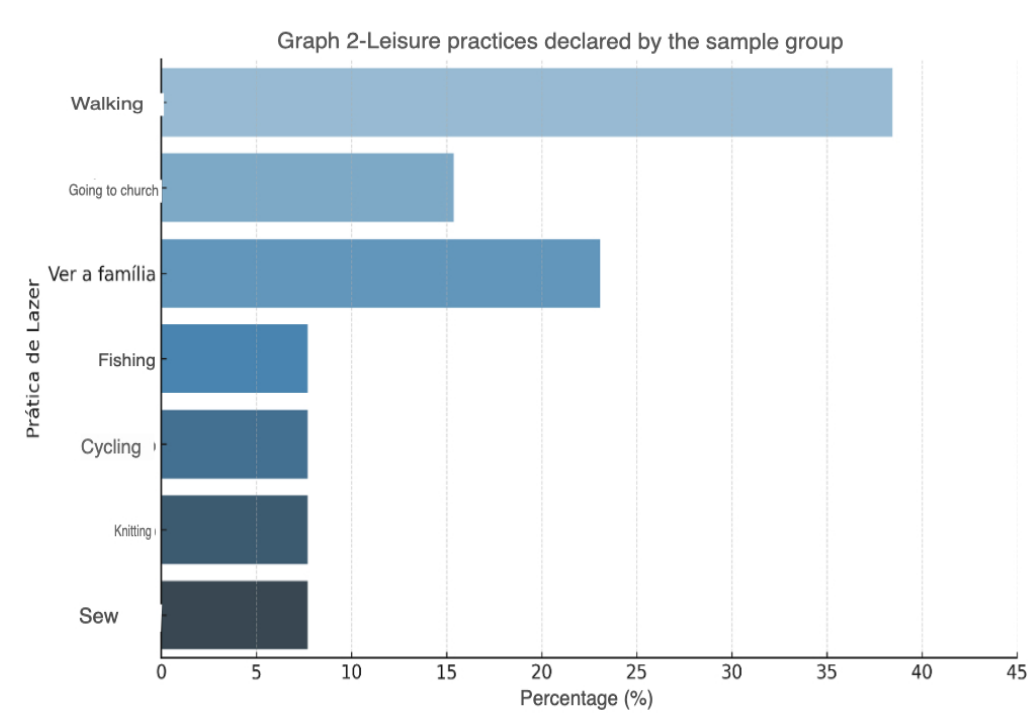
may be related to the age profile of the group and the advancement of the health education process in the communities linked to the Family Health Strategy. In studies conducted by Morillo et al. (2006), it was observed that smokers had significantly higher mean blood pressure values than nonsmokers, even under continuous medication. This reinforces the importance of maintaining professional alertness even among users who report not smoking, especially when there are clinical signs of uncontrolled blood pressure.

Regarding the practice of physical activity, 46.15% of the participants stated that they performed some type of regular exercise, with walking being the most frequent activity, followed by cycling. The relevance of this practice for blood pressure control is widely recognized in the literature. Studies by Nogueira et al. (2012) and Lin and Lee (2018) show that aerobic exercise, practiced regularly, contributes to the reduction of systolic and diastolic blood pressure, in addition to improving the functional capacity and cardiovascular fitness of hypertensive patients. In the present study, although adherence to physical activity is still lower than desired, the presence of active individuals indicates a potential to be strengthened by the FHS teams through educational actions and community walking groups.

Leisure practices, in turn, were reported by 92.3% of the participants, who highlighted activities such as going to church, walking, watching television, meeting friends and doing manual work, such as knitting and sewing. The literature recognizes leisure as an essential element for mental health and general well-being, especially in contexts of chronic diseases. According to Baldissera and Bueno (2012), leisure contributes significantly to the reduction of anxiety and stress, factors closely linked to uncontrolled blood pressure. In addition, Mori and Silva (2010) observe that the presence of family ties and the maintenance of affective bonds are associated with a better physiological response to the treatment of SAH, which was also identified in the present sample.



Graph 2 – Leisure practices declared by the sample group



Source: Field research, 2024.

These data demonstrate that, although the group presents important protective behaviors, such as abstention from tobacco and alcohol and the presence of leisure practices and, in part, physical exercise, there are still gaps regarding the regularity and intensity of these actions. As pointed out by Santos et al. (2005), the effectiveness of non-pharmacological measures depends on their constancy and adequate guidance on the part of health professionals. Thus, the extension experience allowed not only to identify the habits reported by the participants, but also to reflect on the importance of reinforcing systematic educational practices adapted to the sociocultural conditions of each territory.

Regarding pharmacological treatment, it was observed that 100% of the interviewees used antihypertensive drugs, which reflects partial access to the clinical protocol for hypertension management within the scope of the SUS. This universality, however, should not be interpreted as synonymous with full therapeutic adherence, since 15.38% of the participants reported difficulty

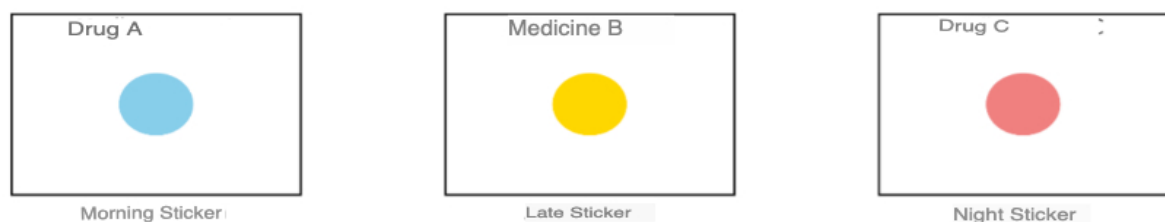


in correctly organizing medication schedules, a fact that directly impacts the effectiveness of the treatment. According to Sousa and Santiago (2018), medication adherence involves not only the possession of medications, but the understanding of their importance, regular use, and management of side effects, aspects that still present weaknesses in the context of primary care.

The presence of difficulties in adherence was especially noted among illiterate and elderly participants with a history of frequent forgetfulness. The phenomenon of polypharmacy, frequent in this population, aggravates this scenario. As pointed out by Nascimento et al. (2019), the use of many medications increases the chance of drug interactions and the risk of adverse effects, in addition to compromising memory and understanding of the therapeutic scheme. In the sample studied, at least three participants reported confusing the time and name of the medications, and it was common to report ingestion outside the schedule or even on an empty stomach, contrary to the clinical prescription.

To mitigate these difficulties, an educational strategy was used based on the use of colored stickers: blue for morning, yellow for afternoon and red for night, pasted directly on the drug packages. This simple and low-cost intervention proved to be effective as a resource to facilitate the therapeutic routine, especially for subjects with low education. According to Silva et al. (2022), visual and tactile resources are effective in promoting therapeutic adherence among patients with cognitive difficulties, especially when inserted in a context of humanized and individualized care. The use of colors, in this case, allowed an intuitive association and was well accepted by the participants.

Figure 1 - example of Organization of medicines with colored stickers



Source: Prepared by the authors, 2024.



During the dialogues with the interviewees, it was also observed that many of them received help from family members, neighbors or community agents to control their blood pressure and provide guidance on the use of medications. This informal support network is essential for the home care of people with chronic diseases. For Ciosak et al. (2013), hypertension, as a condition of continuous management, requires collaborative strategies that involve not only the patient, but also their social environment, favoring co-responsibility and shared surveillance. The extension observation of this community bond allowed students to understand the importance of support networks in therapeutic success, especially in territories marked by vulnerability.

Despite individual and community efforts, two of the interviewees (15.38%) reported recent episodes of hypertensive crises, with symptoms such as severe headache, blurred vision, and a feeling of pressure in the chest. These reports show that the simple prescription of medications is not enough to guarantee the clinical control of hypertension. According to Cha et al. (2012), the subjective perception of symptoms and the way the patient deals with them have a strong influence on adherence and treatment effectiveness. This reinforces the need for continuous monitoring, frequent educational interventions and, above all, qualified listening during primary care care.

During the home visits, it was possible to identify that 53.85% of the interviewees reported symptoms compatible with uncontrolled blood pressure, the most frequent being: persistent headaches, blurred vision, dizziness, sensation of pressure in the neck and palpitations. These findings, although subjective, are consistent with those described in the medical literature on clinical signs of poorly controlled hypertension. According to Rodrigues et al. (2021), even medicated patients may present symptoms as a result of hypertensive peaks caused by stress, inadequate diet, or failures in therapeutic adherence. This reinforces the need for continuous and personalized follow-up, with an emphasis on listening and evaluating warning signs.

Blood pressure was measured during the consultations with the consent of the participants and revealed that approximately 38.5% had levels above the reference values ($\geq 140/90$ mmHg), even



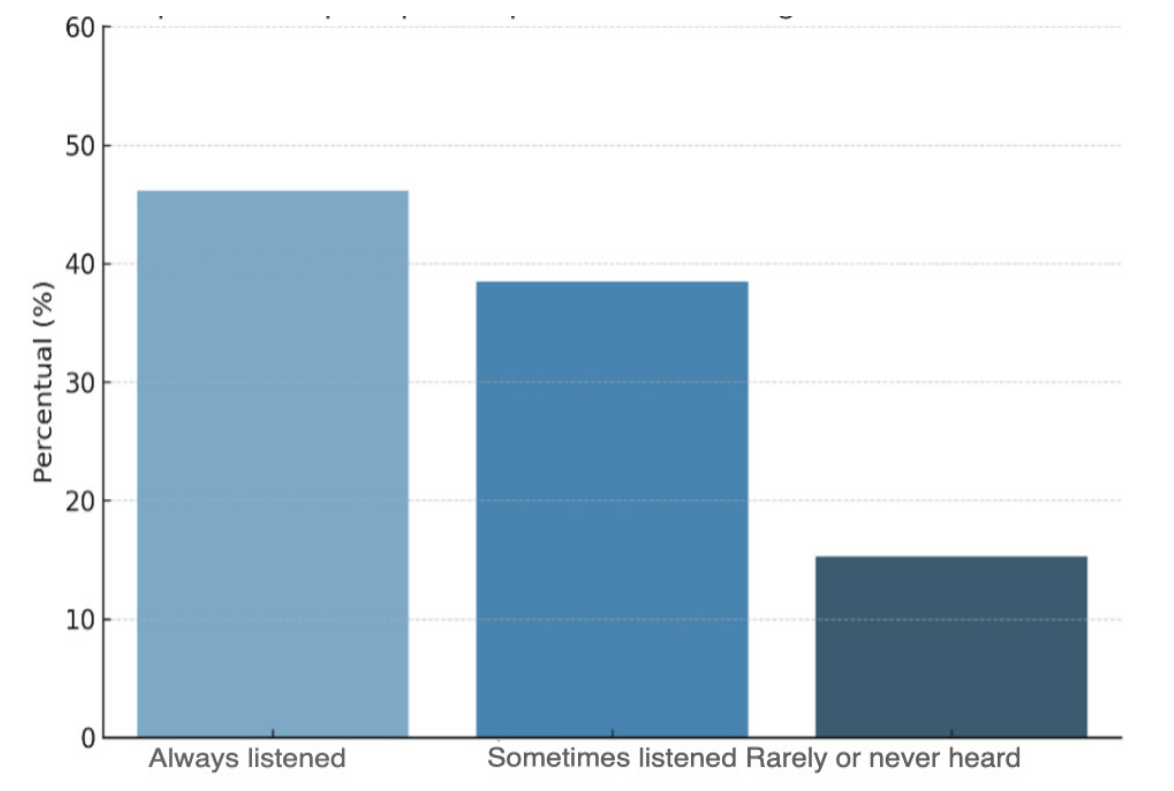
with regular use of medications. This data reinforces the idea that the control of SAH goes beyond the use of medication, requiring behavioral changes and constant vigilance. According to the Brazilian Society of Hypertension (2020), about 50% of hypertensive patients in Brazil have inadequate blood pressure control, which is due to both low adherence and insufficient comprehensive care offered in basic health units.

Another relevant piece of data refers to the participants' perception of listening to health professionals. About 46.15% stated that they "always feel heard" in consultations, while 38.5% answered that they are "sometimes" listened to and 15.3% reported that they "rarely or never" feel heard. These results demonstrate advances in the bond between user and team, but still indicate gaps in health communication. As Ayres (2004) points out, qualified listening is one of the pillars for expanded health care, being indispensable for the construction of a therapeutic project that respects the uniqueness of each subject and their life history.

The perception of partial or non-existent listening has direct implications for treatment adherence and the user's sense of belonging to the service. According to Schraiber and Mendes-Gonçalves (2018), when health professionals assume a verticalized and technicist posture, the care relationship is weakened, generating distance and distrust on the part of the user. In the present study, the reports of intermittent listening indicate that, although there is effort on the part of the teams, investments are still needed in continuous training processes that emphasize welcoming, bonding and empathetic communication as central elements of care.



Graph 3 – Users’ perception of professional listening in the UBS



Source: Field Research, 2024.

In this sense, the extension project allowed medical students to experience, in practice, the complexity of the relationships established between users and professionals of the Family Health Strategy. Direct observation, combined with dialogue with the participants, revealed that listening is not restricted to verbalization, but involves attitudes, body language, available time and ethical posture in the face of the suffering of others. As Franco (2013) points out, listening is a clinical and political device, which requires from the professional not only technical availability, but also human sensitivity. The experience contributed, therefore, to the training of physicians who were more attentive to the subjective dimensions of care.

The strengthening of the bond between users and the Family Health Strategy (FHS) teams emerged as one of the central elements observed during the participatory diagnosis. Most of the



interviewees reported knowing the professionals who work in their area by name, which reveals a certain degree of affective closeness and trust. This type of bond is fundamental for the success of prevention and health promotion actions, as highlighted by Starfield (2002), who points to continuity of care as one of the essential attributes of primary care. In the context of hypertension, where the maintenance of treatment depends on continuous follow-up, this link between professional and patient represents a determining factor.

Despite the positive reference to professionals, some participants reported excessive turnover of doctors and nurses in the unit, which makes it difficult to consolidate lasting bonds. This reality is common in municipalities in the interior, where temporary hiring and low retention of professionals compromise the longitudinality of care. According to Mendes (2011), the discontinuity of the technical team disrupts the territorialized planning of primary care, weakens the singular therapeutic project and disfavors the control of chronic conditions such as arterial hypertension. In the present report, this frailty was reported by elderly people who, over time, were monitored by different professionals, which affected the quality of listening and safety in treatment.

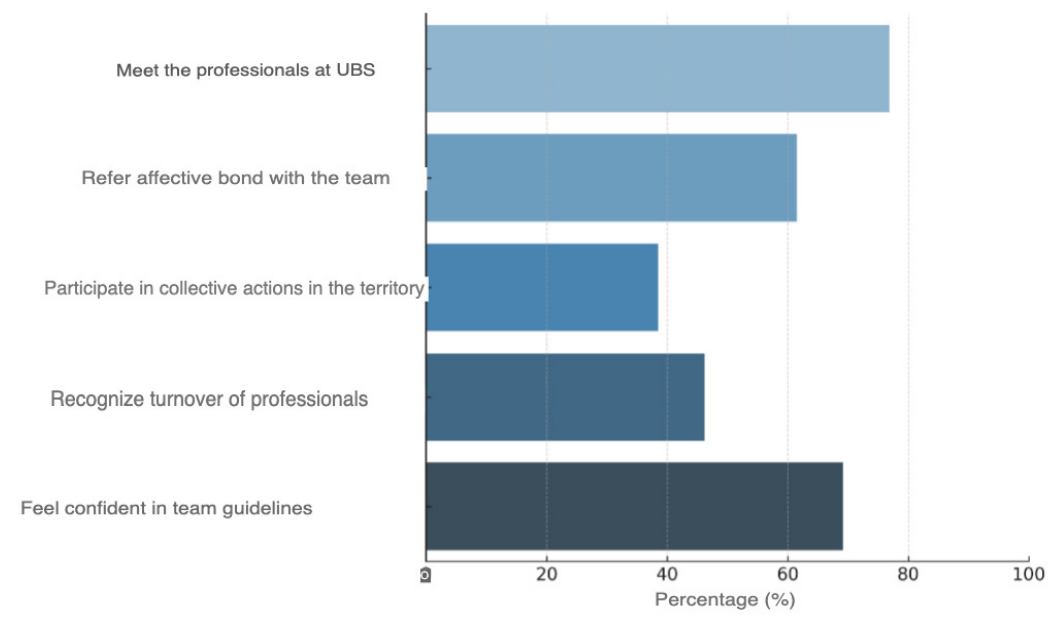
Territorialization, a structuring principle of the FHS, was also evidenced in the experience. The health professionals were well aware of the environmental, socioeconomic and family conditions of the residents served, which facilitated the construction of guidelines adjusted to the local reality. According to Campos and Campos (2006), the recognition of the territory as a living and dynamic space allows care to be constructed in a contextualized way, sensitive to the vulnerabilities and potentialities of each community. The extension observation revealed that, even in the face of scarcity of material resources, the teams sought creative ways to act, using community spaces and local support networks to promote educational meetings and self-care actions.

From the pedagogical point of view, the experience in the territory represented a significant expansion of the medical training of those involved in the project. The approach to the users and the listening to their stories allowed for a situated learning, which goes beyond the limits of the classroom and challenges traditional medical rationality. As Ceccim and Feuerwerker (2004) argue,



extension activities enable formative experiences that promote the articulation between academic and popular knowledge, contributing to the construction of ethical, political and communicational skills indispensable to medical practice in the SUS. The students' reports showed greater empathy, understanding of social determinants and appreciation of teamwork after the experience.

Graph 4 – Representation of the bond and territorialization from the perception of users



Source: Field Research, 2024.

Finally, the experience demonstrated that the direct involvement of students in the health actions of the territory not only enriches their technical training, but also stimulates the commitment to humanized care and the transformation of local realities. As pointed out by Paulo Freire (1996), “no one educates anyone, no one educates himself, men educate themselves, mediated by the world”. In this sense, health education carried out in contact with the territory also becomes a process of re-education of future professionals, to the extent that it brings academic knowledge closer to people's concrete lives, their needs, values and experiences.



The analysis of the social determinants of the participants' health revealed a significant socioeconomic vulnerability. Approximately 76.9% of the interviewees lived with a monthly income of less than two minimum wages, most of whom were retired or unemployed. This data has a direct impact on the ability of individuals to maintain a care routine, including adequate nutrition, acquisition of complementary medications not offered by the SUS, and regular physical activity. According to Buss and Pellegrini Filho (2007), social determinants are configured as structuring elements of the health-disease process, and should be considered as priority axes in the formulation of public policies and in the planning of health actions.

Housing conditions were also pointed out as factors that negatively impact the health of the interviewees. Several participants reported living in homes with a precarious structure, without adequate ventilation or natural lighting, which contributes to a sedentary lifestyle, social isolation and the worsening of comorbidities, such as diabetes and obesity. For Barata (2009), the physical environment in which one lives exerts a direct influence on the quality of life and the control of chronic diseases, and it is essential that health surveillance incorporates such elements in its territorialized action.

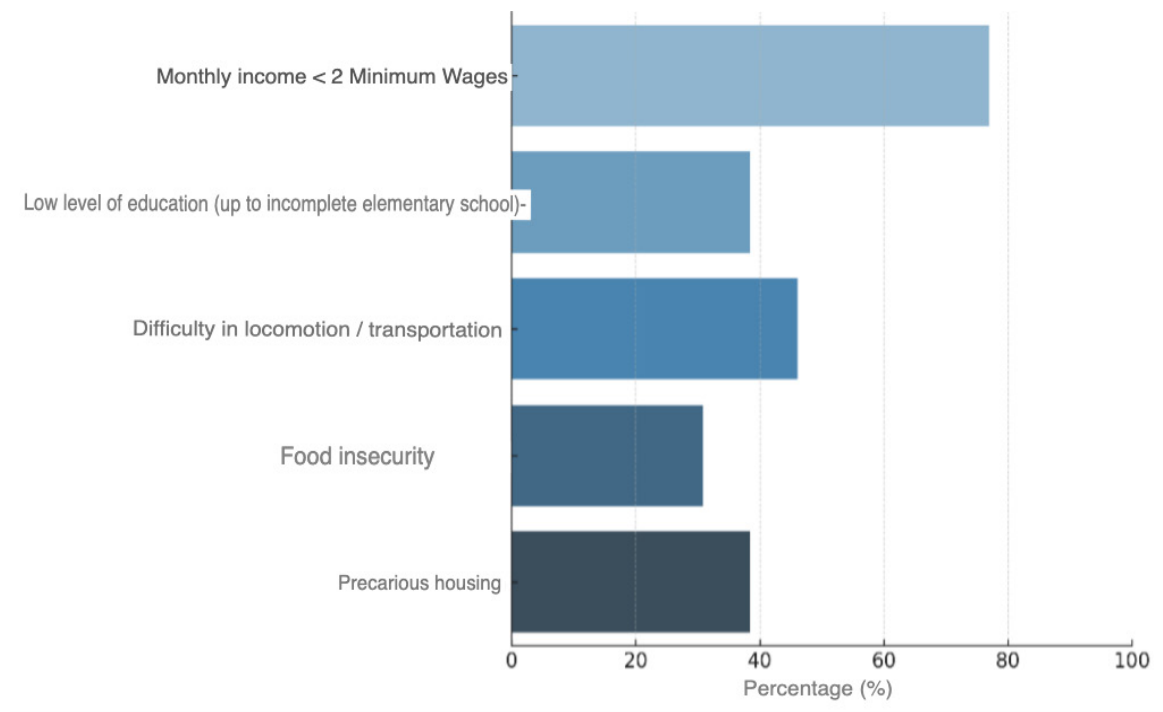
Another important aspect identified in the study was the relationship between schooling and understanding of treatment. About 38.5% of the participants were illiterate or had only incomplete elementary school, which had a direct impact on the understanding of medical prescriptions, the organization of medication and adherence to healthy practices. According to Paim (2013), schooling is an important indicator of access to health information, and its absence tends to compromise the subject's autonomy in self-care. This finding reinforces the need for personalized educational strategies, with accessible language and visual methods, such as those used in the project.

The absence of regular public transportation in the peripheral regions and the difficulty in locomotion reported by the elderly were also identified as barriers to continuous follow-up in the UBS. In some situations, the interviewees reported interrupting the treatment because they were unable to attend the review appointments or pick up the medications at the unit. According to Almeida Filho



(2018), geographic access continues to be an important challenge for the consolidation of primary care in Brazil, especially in municipalities with disorderly urban expansion. Such conditions reinforce the importance of home visits and the work of community health agents as a strategy for approximation and continuity of care.

Graph 5 – Socioeconomic conditions and barriers to care identified in the participants



Source: Field Research, 2024.

Finally, food insecurity was directly mentioned by four interviewees, who reported difficulty in maintaining an adequate diet to control blood pressure, especially with regard to the intake of fruits, vegetables and foods with low sodium content. The restrictive diet recommended for hypertensive patients, despite being widely disseminated, comes up against the economic and cultural limitations of the public served. As Jaime and Figueiredo (2014) point out, the promotion of healthy eating must be articulated with food and nutritional security policies, ensuring physical, financial and symbolic



access to healthy foods. In the context of the research, it was evident that, in addition to technical guidance, it is necessary to understand and act on the real conditions that limit food choices.

The extension experience lived by the students during the participatory diagnosis allowed the articulation between theoretical knowledge and practice in real territory, reaffirming the social function of the university. Direct contact with SUS users, mostly elderly people and in vulnerable situations, generated deep reflections on the limits of medical practice and the importance of effective and humanized communication practices. According to Ceccim and Feuerwerker (2004), medical education should integrate ethical-political and sociocultural components, promoting the development of competencies that go beyond the technical domain and promote active listening, welcoming and co-responsibility.

The students reported, in their written feedback, that the experience contributed to the resignification of their perception of systemic arterial hypertension. Instead of understanding the condition only as a clinical diagnosis based on blood pressure parameters, they began to perceive its complexity as a social, relational, and historical phenomenon. According to Campos (2000), comprehensive care is only possible when the professional recognizes the subject in its entirety, considering the multiple determinants that affect their health. In this sense, the exercise of critical observation and dialogue with users were essential formative elements.

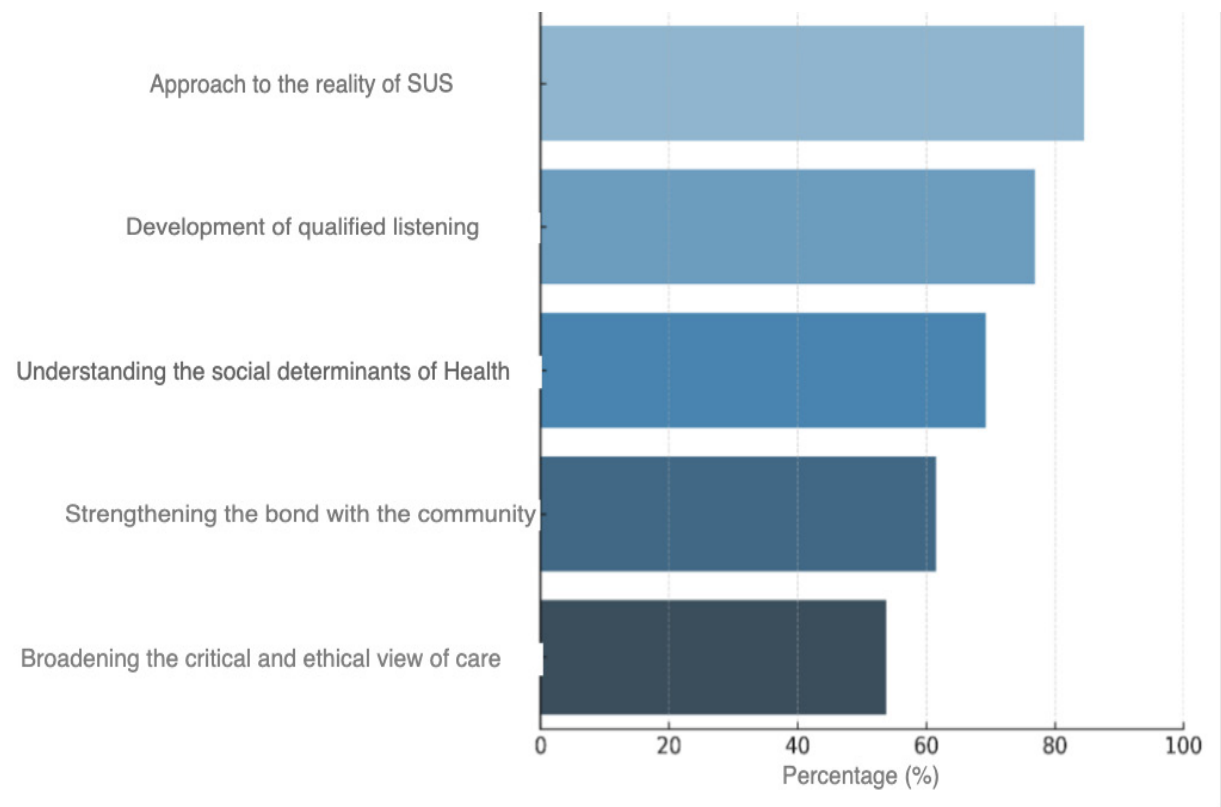
Another relevant impact was the recognition of the importance of nonviolent communication and accessible language. Many students reported initial difficulties in adapting the biomedical vocabulary to the comprehension needs of users, especially those with low education. Over time, they developed facilitating strategies, such as the use of drawings, diagrams and visual materials, including in the organization of medications. This practice is aligned with the National Curriculum Guidelines for Medical Courses, which emphasize the training of professionals capable of establishing effective, sensitive and appropriate communication in different contexts (Brasil, 2014).

The extension practice also favored multiprofessional teamwork and the appreciation of local knowledge. At various times during the activity, the students observed how the Community



Health Agents played a fundamental role in the mediation between the UBS team and the community, offering information about routines, habits, access difficulties and affective bonds. This recognition of the interdependence between technical knowledge and popular knowledge is one of the foundations of popular health education, as discussed by Vasconcelos (2008), and represents an advance in the process of building subjects committed to the transformation of social realities.

Graph 6 – Students’ perception of the impact of the extension experience on medical education



Source: Field Research, 2024.

Finally, the students themselves highlighted the relevance of the activity for the consolidation of their professional identity in training. The exercise of listening, the understanding of the social determinants of health, the recognition of the SUS as a fundamental public policy and the experience



of the territory as a pedagogical space were mentioned as significant milestones in the academic trajectory. Such elements converge with the concept of critical-reflective competence, proposed by Almeida et al. (2021), which considers essential the ability to analyze contexts, dialogue with subjects, and build unique solutions to complex problems in the field of health.

The educational interventions carried out during the participatory diagnosis demonstrated formative potential for both students and users. Through conversation circles, individual guidance and adapted visual materials, it was possible to stimulate the participants' protagonism in the management of their own chronic condition. The use of accessible pedagogical strategies, such as the organization of medications with colored stickers, facilitated the understanding of schedules and dosages, especially among those with low education. According to Freire (1996), the educational process is only effective when it starts from the concrete reality of the subjects, allowing them to recognize themselves as agents of transformation of their own lives.

The Basic Health Unit (UBS), as the locus of extension action, played an essential role in the articulation between clinical care and educational practices. The partnership between the UBS team and the extension workers enabled an expanded listening, welcoming spontaneous demands and strengthening the bond with the community. As stated by Campos and Domitti (2007), the UBSS should be privileged spaces for shared care and the construction of therapeutic projects that consider not only the disease, but the users' way of life. The analyzed experience showed how the presence of students can dynamize this process, contributing to the dialogue between academic knowledge and popular knowledge.

In addition to the immediate results on care, the project revealed potential for replicability in other territories, especially in communities with similar sociodemographic characteristics. The systematization of the experience, with a detailed description of the method, instruments and approach, allows other higher education institutions to replicate the methodology with the appropriate contextual adjustments. This perspective is in line with the principles of Brazilian university extension, which advocate the inseparability between teaching, research and extension, and the social feedback of the



knowledge produced at the university (Brasil, 2018).

The engagement of students in all stages of extension action was also configured as a transversal training process, capable of fostering listening skills, critical analysis, empathy and planning in collective health. These competencies are considered central to contemporary medical education, especially in a public health system such as the Brazilian one, which requires professionals capable of working as a team, understanding the territory, and building joint solutions with the community. As Schraiber (2010) points out, training for the SUS requires going beyond technique, promoting critical, ethical training focused on social commitment.

Thus, the reported action reaffirms the pedagogical value of university extension as an active and contextualized methodology, which favors meaningful learning and contributes to the training of physicians who are more sensitive to social inequalities. The collective construction of the diagnosis, anchored in listening and presence in the territory, proved to be a powerful tool not only to identify health demands, but also to broaden the educational horizons of future professionals.

FINAL CONSIDERATIONS

The experience of participatory diagnosis of hypertensive patients in the Family Health Strategy, developed in the city of Eunápolis-BA, reaffirmed the transformative potential of university extension as a space for ethical, critical and sensitive training for future doctors. By dialoguing with users in their real life contexts, the students were able to understand, in depth, the multiple dimensions of the health-disease process and the concrete challenges faced by people with systemic arterial hypertension. The territory, more than a scenario, has become a formative subject, revealing vulnerabilities, powers and meanings that would hardly emerge only in formal teaching environments.

This encounter between technical-scientific knowledge and popular knowledge not only qualified the care experience, but also promoted a dialogic and horizontal health education. The students were invited to listen, observe and respect the times, speeches and silences of the users,



recognizing that care is only effective when it starts from authentic listening and recognition of the other in their uniqueness. The practices developed during the action showed that it is possible to intervene in a simple, accessible and powerful way, as long as it is understood that the centrality of care is in the people and their stories.

It is therefore concluded that actions such as this should be encouraged and systematized as a structuring part of medical education in Brazil. The inseparability between teaching, research and extension, when experienced with social responsibility and ethical commitment, contributes not only to the training of more complete professionals, but to the construction of a fairer society, attentive to inequalities and committed to the right to health. The SUS, as a public policy of inclusion and care, needs to be experienced, felt, and defended since graduation, and university extension is, without a doubt, one of the most powerful paths for this learning.

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