

DOI: <https://doi.org/10.36489/saudecoletiva.2021v11i66p6415-6424>

# Adherence and therapy of hypertensive users assisted by a family health strategy team

Adherencia al tratamiento de usuarios hipertensos asistidos por un equipo de estrategia de salud de la familia

Adesão ao tratamento de usuários hipertensos assistidos por uma equipe de estratégia da saúde da família

## ABSTRACT

**Objective:** The present study aims to report the experiences of an intervention project on sensitization in adhering to the treatment of users diagnosed with systemic arterial hypertension in a Basic Family Health Unit. **Methods:** Es un relato de experiencia, con enfoque cualitativo. El proyecto involucró a usuarios hipertensos que estaban siendo monitoreados en un hospital asistido por un equipo de estrategia de salud familiar en la ciudad de Manaus, AM. **Results:** 40 users participated in the operational group. Of these, 19 were female and 21 male, aged 60 to 79 years. As for the Framingham cardiovascular risk stratification, 30 users were in the high risk category and 10 at moderate risk. **Conclusion:** Actions for this population enable an improvement in knowledge about hypertension, its complications and treatment measures and, consequently, greater adherence to treatment.

**DESCRIPTORS:** Family health strategy; systemic arterial hypertension; health care; health education.

## RESUMEN

**Objetivo:** El presente estudio tiene como objetivo relatar las experiencias de un proyecto de intervención sobre sensibilización en la adherencia al tratamiento de usuarios diagnosticados de hipertensión arterial sistémica en una Unidad Básica de Salud de la Familia. **Métodos:** Se trata de un relato de experiencia, con enfoque cualitativo. Los usuarios hipertensos que participan en una estrategia de salud familiar participaron del proyecto en la ciudad de Manaus, AM. **Resultados:** 40 usuarios participaron en el grupo operativo. De ellos, 19 eran mujeres y 21 hombres, de entre 60 y 79 años. En cuanto a la estratificación de riesgo cardiovascular de Framingham, 30 usuarios estaban en la categoría de alto riesgo y 10 en riesgo moderado. **Conclusión:** Las acciones dirigidas a esta población permiten mejorar el conocimiento sobre la hipertensión, sus complicaciones y medidas de tratamiento y, en consecuencia, una mayor adherencia al tratamiento.

**DESCRIPTORES:** estrategia de salud de la familia; hipertensión arterial sistémica; atención en salud; educación en salud.

## RESUMO

**Objetivo:** O presente estudo tem por objetivo relatar às experiências de um projeto de intervenção sobre a sensibilização na adesão ao tratamento de usuários com diagnóstico de Hipertensão arterial sistêmica em uma Unidade Básica de Saúde da Família. **Métodos:** Trata-se de um relato de experiência, de abordagem qualitativa. Participaram do projeto usuários hipertensos assistidos por uma equipe de estratégia saúde da família no município de Manaus, AM. **Resultados:** Participaram do grupo operacional 40 usuários. Destes, 19 eram do sexo feminino e 21 do sexo masculino, com idade entre 60 a 79 anos. Quanto à estratificação de risco cardiovascular de Framingham, 30 usuários encontravam-se na categoria de alto risco e 10 em risco moderado. **Conclusão:** Ações a esta população possibilitam o maior conhecimento sobre a hipertensão, suas complicações e medidas terapêuticas e maior adesão ao tratamento destes pacientes.

**DESCRIPTORIOS:** Estratégia saúde da família; hipertensão arterial sistêmica; assistência à saúde; educação em saúde.

RECEIVED ON: 10/15/2021 APPROVED ON: 02/12/2021

### Erika Gomes Alves

Physiotherapist. Manaus Public Health School – ESAP.  
ORCID: 0000-0002-4565-4775

### Nádia Cardoso Martins

Nurse. Manaus Public Health School – ESAP.  
ORCID: 0000-0002-1107-4270

## Rednaj Mota Santos

Nurse. Manaus Public Health School – ESAP.  
ORCID: 0000-0001-6558-9758

## Sabrina Sonra Miranda da Silva

Nurse. Manaus Public Health School – ESAP.  
ORCID: 0000-0003-0141-4769

## Sandra Deyse Rodrigues Souza Ferreira

Nurse. Manaus Public Health School – ESAP.  
ORCID: 0000-0002-3946-6743

## INTRODUCTION

**C**hronic Noncommunicable Diseases (CNCD) are one of the biggest public health problems in Brazil and in the world. Systemic arterial hypertension (SAH) is among the five main diseases that, when not controlled, cause a series of complications, such as cardiovascular and kidney diseases, increasing the number of hospital admissions and generating high costs for the individual and society.<sup>1</sup>

SAH is defined as a multifactorial clinical condition characterized by elevation and support of blood pressure levels  $\geq 140$  and/or 90 mmHg frequently associated with metabolic disorders, functional and/or structural changes in target organs.<sup>2</sup>

SAH has three important characteristics, the first being prevalence: it is responsible for a significant portion of consultations in the basic network; the second is transcendence, considered one of the main risk factors associated with stroke, acute myocardial infarction (AMI). And finally, we have the vulnerability, which is easily treatable and controllable within the scope of Primary Health Care (PHC), since 50 to 80% of cases are resolved in the basic network.<sup>3</sup>

PHC is the gateway for users in the prevention, control and treatment of chronic diseases such as SAH, and it is their responsibility to favor the link with the community and the clientele of the assigned area, working on factors that need to be adequately addressed and controlled, taking account racial,

cultural, religious diversity and the social factors involved.<sup>4</sup>

The PHC team is of paramount importance in the strategies for prevention, diagnosis, monitoring and control of arterial hypertension. They must also always focus on the fundamental principle of person-centered practice and, consequently, involve users and caregivers, at the individual and collective level, in the definition and implementation of strategies to control hypertension.<sup>4</sup>

Treatment for SAH is characterized as non-medicated and medicated, both, individually or in combination, aim to reduce cardiovascular morbidity and mortality. People with mild hypertension can be treated without the use of medication, through lifestyle changes, adequate nutrition, especially regarding salt consumption and weight control, physical activity, smoking cessation and reduced excessive use of alcohol.<sup>4,5</sup>

Drug therapy is based on the use of diuretic drugs, beta-blockers, angiotensin-converting enzyme inhibitors, angiotensin AT1 receptor blockers (BRA II), and calcium channel antagonists, for combined or individual use, reducing blood pressure and fatal and non-fatal cardiovascular events.<sup>6</sup>

In the routine of the health units, the user with SAH is a constant visitor in search of the renewal of prescriptions, follow-up consultation, pressure check and care for the aggravation of their chronic condition, among others, however, many of these visits can be related to non-adherence to a prescribed drug tre-

atment, a situation that can occur due to several factors.<sup>7,8</sup>

Adherence to the pharmacological treatment of SAH is considered one of the essential steps to guarantee its success. Therefore, the knowledge of the disease, its complications and the need for changes in relation to lifestyle, requires from the patient, in addition to motivation, continuous and shared guidance.

Non-adherence to treatment results in aggravations in the pathological process, an increase in the number of morbidities and hospital admissions. Thus, measures that encourage better therapeutic adherence are important, by strengthening the bond between professionals and users, in addition to the development of education, prevention and health promotion actions.

This work aims to report the experiences of an intervention project (IP) on sensitization in adhering to the treatment of users diagnosed with systemic arterial hypertension in a Basic Family Health Unit.

## METHOD

It is an experience report, with a qualitative and descriptive approach, of an intervention project (IP) carried out in a Basic Family Health Unit, in the East Zone, from January to February 2020, in the city of Manaus, Amazonas. This PI is part of the conclusion work of the Specialization Course in Public Health, with an emphasis on Family Health Strategy conducted by the School of Public Health of Manaus (ESAP - Escola de Saúde Pública) in partnership with

the University of the State of Amazonas (UEA - Universidade do Estado do Amazonas).

The health unit has seven micro-areas inserted in its territory being composed of (1) doctor, (1) nurse, (2) nursing technicians and (7) community health agents - CHA's.

The activities were developed through the organization of an operational group of hypertensive users (n=40). The actions performed were: home consultation, cardiovascular risk classification, epidemiological survey and educational group, with the main focus on the level of understanding of the information obtained, the relationships within the group and the feelings and expectations reported.

Participated in the operational group users assisted by the ESF who met the following criteria: diagnosis of SAH, being regularly registered in the e-SUS information system (complete), updated laboratory tests (lipidogram, urea and creatine) (up to 12 months), classified with moderate or high cardiovascular risk from Framingham stratification. The intervention project was ineligible: users with a wrong and late diagnosis of SAH, patients who refused home visits and who were not at home.

Adherence to the treatment of hypertensive members of the operational group was determined through self-report, during an interview, guaranteeing total confidentiality and respect for the user.

As for the cardiovascular risk classification, the Framingham score and the cardiac risk calculator application were used, with the patient being classified into the following categories: low, intermediate/moderate and high risk. This app calculates cardiovascular risk based on some user input parameters and the Framingham equation.

The execution of the IP was divided into three stages:

1st stage: team training, user tracking. In this phase, permanent education was carried out with the profes-

**The activities were developed through the organization of an operational group of hypertensive users (n=40). The actions performed were: home consultation, cardiovascular risk classification, epidemiological survey and educational group, with the main focus on the level of understanding of the information obtained, the relationships within the group and the feelings and expectations reported.**

nals who are part of the FHS through the conversation wheel, the themes were addressed: systemic arterial hypertension, medication and non-medication adherence, home care and health education. The objective of the activity was to identify the CHA's prior knowledge about the proposed application of the intervention project and to invite them to collaborate directly on the project.

2nd stage: home visit, treatment adherence and cardiovascular risk classification. Treatment adherence was assessed based on self-report during home visits. These occurred, once a week, and were carried out by specialized nurses and CHAs, organized in two groups. Each group was composed of an ACS and two specialized nurses. During the home care activities, anthropometric assessments, blood pressure levels, clinical nursing care, multidimensional assessment and invitation to health education activities were carried out.

3rd stage: health education actions in an operational group (2 meetings). The topics covered in the group activities were: DCNT; drug and non-drug treatment; healthy eating and the importance of physical activity. In this stage, health education activities were carried out for the group of patients diagnosed with SAH. Two meetings were held, before the proposed activity, the pressure levels, weight, height and abdominal circumference of all participants were checked. The data were recorded and used as a basis for therapeutic guidance during the consultation at home.

The first health education action was carried out in the morning, lasting two hours. The activity was mediated by pharmaceutical professionals and a nutritionist, both professionals from the Eastern Health District - DISAL. The conversation wheel was used as a methodology, addressing the following themes: medications used for SAH, medication and non-medication adherence, lifestyle and healthy eating.

The second meeting was held in the afternoon. Professionals were present

to mediate the action: dentists and specialized nurses. The following topics were addressed in the conversation: oral hygiene, care of teeth and dental prostheses, challenges regarding outpatient access, access to pharmacy and medications prescribed by the doctor, and systematic care of professional nurses and doctors.

The data were organized and subsequently analyzed based on the users' experience regarding the disease and the treatment measures. The data were entered into a Microsoft Excel 2019 database, the variables were presented descriptively through tables.

This study was approved by the Human Research Ethics Committee of the Federal University of Amazonas - UFAM, with CAAE nº 20092919.5.00005020.

## RESULTS

Of the total registered users (3.266), one hundred and sixty-four (164) were hypertensive and seventy-two (72) were hypertensive and diabetic. The sample consisted of 40 hypertensive patients, of whom (21) were men. There was a predominance of participants aged 60 to 70 years. Regarding education, most reported having completed elementary school (19). As for cardiovascular risk

based on the Framingham score, we found that (30) users were at high risk and (10) were at moderate risk. Below we present the characterization of the participants (table 1).

As for the Framingham cardiovascular risk stratification, 30 users were in the high risk category and 10 at moderate risk.

Regarding therapeutic adherence, 2 groups of users were identified: those who partially adhered or did not adhere to the proposed treatment. Among the main difficulties reported regarding adherence to treatment by these individuals, are: carrying out domestic activities, taking care of family members, distancing from children, low income, ignorance of government programs, incorrect use of antihypertensive medications, difficulty in understanding about prescription, schedules, adverse reactions, concomitant use with other medications and herbal medicines.

## DISCUSSION

Adherence to treatment is a phenomenon that can involve multiple factors related to the patient, therapeutic prescription, pathology, access to health services, as well as the social and cultural environment of the user and his family. Based on the identification of these fac-

tors, it is possible to establish intervention measures.

The establishment of a good relationship between health professionals and patients can improve adherence to treatment. The differentiated approach of the different professionals that make up the FHS is fundamental for a better approach to NCDs. Large health systems, such as the Unified Health System (SUS), are based on multi-professional teams.<sup>9</sup>

The management of activities such as: conversation circle, lectures and dynamics provide interactivity between patients and professionals, enabling the exchange of knowledge and practices, making them able to understand and learn the disease process and consequently assist in the correct form of treatment, conduct and empowerment for self-care to be performed in the course of complications or not of SAH.<sup>10</sup> The home visit should be used as an appropriate technology to approach the individual in his family and community aspect, as an important strategy for health promotion and as a potent inducer of change in the techno-assistance model in health. In addition to representing a space for the exchange of knowledge, it has numerous potentials, such as the strengthening of family care; the creation of bonds between professionals and the community. The home consists of a space for the collective construction of the health team and the user, favors more humanized care and facilitates the identification of the difficulties that allow a different view of the health team for changes in the way of acting adapting them to the social context of each individual.<sup>11,12</sup>

Home care provides professionals with a holistic view of the life of each user, benefiting the implementation of individual or collective strategies that can involve the family and the community, identifying risk factors that may interfere in the health-disease process and carry out interventions with greater chances of success.

Table 1. Characteristics of users of the Basic Health Unit participating in the Intervention Project. Manaus – AM, 2020.

Variable	N (40)
<b>Sex</b>	
Male	21
Female	19
<b>Age</b>	<b>60 to 70</b>
<b>Education</b>	
Elementary School	19
High School	17
Illiterate	4
<b>Framingham Cardiovascular Risk</b>	
High Risk	30
Moderate Risk	10

The lack of knowledge about forms of treatment and self-care measures was constantly reported by users during group activities and home visits. A study carried out at Hospital das Clínicas in São Paulo, with hypertensive patients, showed that 81% of respondents were unaware of non-drug treatment for SAH.<sup>12</sup> It is up to health professionals to constantly reinforce the importance of non-drug treatment in the control of SAH.

PHealth education programs favor the promotion of self-care and make the user more responsible for decisions related to their health. It is important that these activities are developed in a multidisciplinary way, acting in an integrated way in the approach of risk assessment, adoption of health promotion measures and assistance to users of outpatient monitoring services.<sup>13</sup>

The Family Health Strategy program has a wide panorama to work on health promotion, disease prevention, continued care, and user integration according to its epidemiological characteristics.

**The Family Health Strategy program has a wide panorama to work on health promotion, disease prevention, continued care, and user integration according to its epidemiological characteristics.**

## CONCLUSION

The care of users with NCDs represents a challenge for the FHS. Among these diseases, SAH is the most prevalent, being considered a public health problem.

In addition to assistance from the team, there is a need for individual participation in adhering to the proposed treatment. Actions that encourage the empowerment of patients about their disease are important. In addition, due to the complexity of SAH, approaches that involve all professionals in the health unit, users and their families are essential in defining and agreeing on the follow-up goals to be achieved.

The activities in the group of hypertensive patients provided an important space for dialogue for the planning of individual and collective measures for their members. It is the role of the health team to promote facilitating measures that contribute to greater adherence to treatment. The creation of the group was considered fundamental by the users and professionals of the health unit, being based on the principle of comprehensive care. ■

## REFERENCES

1. Da Silva B, et al. Hospitalização por agravos da hipertensão arterial em pacientes da atenção primária. v. 26, n. 4, p. 313-317. São Paulo: Acta Paulista de Enfermagem; 2013.
2. Malachias MVB, et al. 7ª Diretriz Brasileira de Hipertensão Arterial: Capítulo 3 - Avaliação Clínica e Complementar. Arq. Bras. Cardiol. [Internet]. 2016.
3. Malta DC et al. A Política Nacional de Promoção da Saúde e a agenda da atividade física no contexto do SUS. Epidemiologia. Serv. Saúde; 2009.
4. Brasil, Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Estratégias para o cuidado da pessoa com doença crônica: hipertensão arterial sistêmica. Brasília, DF, Ministério da Saúde, 2013.
5. Brandão AA, et al. 6ª Diretrizes de Monitorização Ambulatorial da Pressão Arterial e 4ª Diretrizes de Monitorização Residencial da Pressão Arterial. Arquivos Brasileiros de Cardiologia; 2018.
6. Köhlmann JR, et al. Tratamento medicamentoso. Brazilian Journal of Nephrology, v. 32, p. 29-43, 2010.
7. Brasil, Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Primária em Saúde. Núcleo de Apoio à Saúde da Família. Cadernos de Atenção Primária em Saúde n. 39. Brasília, DF, Ministério da Saúde 2014.
8. Brasil, Ministério da Saúde. Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Departamento de Ciência e Tecnologia. Síntese de evidências para políticas de saúde: adesão ao tratamento medicamentoso por clientes portadores de doenças crônicas. Brasília, DF, Ministério da Saúde, 2016.
9. De Gusmão, J L et al. Adesão ao tratamento em hipertensão arterial sistólica isolada. Rev Bras Hipertens, v. 16, n. 1, p. 38-43, 2009.
10. Oliveira J, et al. Sociedade Brasileira de Diabetes. Diretrizes da Sociedade Brasileira de Diabetes. São Paulo, SP: Editora Clannad; 2018, 2017.
11. Vasconcelos M, et al. Práticas educativas e tecnologias em saúde. Belo Horizonte, MG. Núcleo de Educação em Saúde Coletiva, UFMG; 2014.
12. Drulla, AG, et al. A visita domiciliar como ferramenta ao cuidado familiar. Curitiba, PR. Cogitare Enfermagem; 2009.
13. Mion Jr, et al. Conhecimentos, preferências: o perfil dos hipertensos quanto ao tratamento farmacológico e não farmacológicos. São Paulo, SP. Jornal Brasileiro de Nefrologia; 1995.