Promotion of men's health with analysis of the experiences of elderly with sys-temic arterial hypertension

Promoção a saúde do homem com análise das experiências dos idosos com hipertensão arterial sistêmica

Promoción de la salud de los hombres con análisis de las experiencias de ancianos con hipertensión arterial sistémica

RESUMO

Objetivo: Analisar as experiências dos homens idosos com o tratamento da Hipertensão Arterial Sistêmica e suas condições de adoecimento. Método: Foi realizado um estudo descritivo, baseado em metodologia qualitativa, na cidade de Campos Sales-CE, na atenção básica em saúde. Utilizou-se a técnica de uma entrevista semiestruturada, com 21 homens idosos participantes. Resultado: O estudo foi apresentado em uma categorização temática, com elaboração de gráficos, com análise e interpretação dos dados. Foi evidenciado a necessidade de implementar metodologias voltadas à promoção em saúde, assim como inovação dos cuidados prestados da equipe de saúde para subsidiar o matriciamento conforme as singularidades dos usuários do serviço. Conclusão: A atenção básica em saúde representa um cenário oportuno e de grande importância para identificação precoce das necessidades dos homens, pois é a porta de entrada do sistema de saúde responsável pelo acompanhamento próximo e longitudinal.

DESCRITORES: Atenção Básica; Saúde do Homem; Idoso; Hipertensão; Promoção de Saúde.

ABSTRACT

To analyze the experiences of elderly people with the treatment of Systemic Arterial Hypertension and their disease conditions. Method: A descriptive study, with qualita-tive methodology, was carried out in the municipality of Campos Sales-CE, in prima-ry health care. The semi-structured interview technique was used, with 21 elderly participants. Result: The study was presented in a thematic categorization, with the elaboration of graphs, with analysis and interpretation of the data. The need to im-plement methodologies aimed at health promotion was evident, as well as innova-tion in the care provided by the health team to subsidize matrix support according to the singularities of service users. Conclusion: Primary Health Care represents an opportune scenario of great importance for the early identification of men's needs, as it is the gateway to the health system responsible for close and longitudinal moni-toring.

DESCRIPTORS: Primary Care; Men's Health; Elderly. Hypertension; Health Promotion.

RESUMEN

Objetivo: Analizar las experiencias de ancianos con el tratamiento de la Hiperten-sión Arterial Sistémica y sus condiciones de enfermedad. Método: Se realizó un es-tudio descriptivo, basado en metodología cualitativa, en la ciudad de Campos Sales-CE, en la atención primaria de salud. Se utilizó la técnica de entrevista semiestruc-turada, con 21 ancianos participantes. Resultado: El estudio fue presentado en una categorización temática, con elaboración de gráficos, con análisis e interpretación de los datos. Se evidenció la necesidad de implementar metodologías dirigidas a la promoción de la salud, así como la innovación en la atención brindada por el equi-po de salud para subsidiar el apoyo matricial de acuerdo a las singularidades de los usuarios del servicio. Conclusión: La Atención Primaria de Salud representa un es-cenario oportuno de gran importancia para la identificación temprana de las necesi-dades de los hombres, ya que es la puerta de entrada al sistema de salud encarga-do del seguimiento estrecho y longitudinal.

DESCRIPTORES: Atención Primaria; Salud de los hombres; Anciano; Hipertensión Promoción de la Salud.

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INTRODUCTION

In recent years, an important process of reorientation of health care models and care practices has developed, demanding new ways of thinking, feeling and acting from professionals and managers. Increasingly, it appears that the SUS does not refer to a completed and definitive proposal. It is a political project still under construction that is influenced by the socio-historical context and the subjects that constitute it [1].

In the meantime, several policies have been designed to promote assistance to the entire population, given the need to guarantee the principles of the Unified Health System (SUS), especially with regard to universality and equity. Among these is the national policy of comprehensive care to men's health (PNAISH - Política Nacional de Atenção integral à Saúde do Homem), launched in 2009, which aims to reduce male morbidity and mortality and undertake actions that insert men into the daily routine of health services, especially in primary health care (PHC), reducing costs and increasing the effectiveness of actions, in addition to qualifying professionals to serve the male public, promoting actions that accompany the uniqueness of this public. [2]

The fragility of the relationships between the Family Health Strategy and the male public, which produce a kind of invisibility of men in the service, at times, may be an indicator of the inadequacy between men's health needs/expectations and the structure and functioning of health services, particularly PHC services. [3]

Studies show that the male population's demand for public health services is still mostly motivated by illness and emergencies, leading to an aggravation of the health problem, triggering the need to enter the health system often through specialized care and strictly curative care institutions, increasing costs for the SUS and the burden for the person and the family. [4]

Confirming the above, men in general are not educated, oriented and sensitized to take care of themselves, nor to take care of others, and care is commonly associated with the female sphere. They usually access health services through secondary or tertiary care and when they are already in an advanced state of illness. [5]

However, new strategies can be proposed to change this scenario, taking into account that the elderly are endowed with experiences, knowing and analyzing them can be relevant factors for possible proposals to be adopted in PHC and consequently achieve positive results for public health problems, such as systemic arterial hypertension (SAH).

The control of SAH is fundamental, and for that I believe it is necessary that users are educated and informed and participate in decision-making and care planning together with the health professional, assume their care related to the disease with self-responsibility, and understand the complications that can be caused by non-adherence to treatment. Health promotion and a dialogical relationship between professionals-users can become essential for effective treatment.

It is necessary to rebuild the ways of thinking, feeling and acting of the health and management teams, seeking to build more participatory and horizontal assistance proposals. Understanding this process is a step forward for promoting health care practices and for implementing health education strategies, aiming to encourage changes in the risk behaviors of hypertensive men. Such a challenge and its complexity reveal the need to follow paths that are still unfamiliar to health teams, passing through the paths of intersectoriality, networking and popular participation.

The article aims to analyze the experiences of elderly men with the treatment of Systemic Arterial Hypertension and their conditions of illness. The question that guided this study was: Knowing the experiences of elderly men with SAH/CVD, the factors that facilitate/difficult treatment adherence, their senses and perceptions about their illness conditions, can it contribute to the development of assistance policies that promote greater adherence of men to the treatment of SAH?

METHOD

The study was carried out after sending and approving the project submitted to the Research Ethics Committee of the State University of Ceará (number-4,692,251), respecting the ethical aspects foreseen in the current legislation regarding research with human beings.

A descriptive study was carried out, based on methodology with a focus on qualitative research.

As a collection technique, a semi-structured interview was used, with a recorder, with the participant's permission, with open and closed questions previously established and applied individually.

The interview is taken in the broad sense of verbal communication, and in the narrow sense of collecting information on a given scientific topic, it is the most used strategy in the fieldwork process. It is, above all, a conversation between two people, or between several interlocutors, carried out on the initiative of the interviewer. It aims to build relevant information for a research object. 8

The research was carried out in the city of Campos Sales, located in the interior of the state of Ceará, with an estimated population [2020] 27,470 inhabitants, with a demographic density of 24.48 inhab./ Km², according to data from the Brazilian Institute of Geography and Statistics (IBGE) 2010 [7]. This city was chosen because it does not have a study on the subject.

The choice of UBS Centro Dr. Francisco Vitorino de Luna for the study was done because it has, among the 11 UBS in the city of Campos Sales, the largest number of hypertensive elderly people, with a total of 397, according to data obtained through e-SUS with the municipal health department.

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The research participants were 21 elderly men with SAH/CVD, registered and assisted at UBS Centro Dr. Francisco Vitorino de Luna, oriented in time and space and in clinical conditions to participate in the study.

The collection was carried out during the months of June to August 20221. After carrying out the research, the statements were transcribed as an integral part of the methodological construction.

A visit was made to the UBS by scheduling a consultation for hypertensive patients to apply an interview to the male elderly, elderly affected by SAH, as the demand for the UBS was small due to the current scenario of the COVID-19 pandemic, in order to obtain a greater number of data collection, a home visit was carried out to the elderly belonging to the area covered.

An exposition was made pointing out the result of the study, with the content of the data presented in a thematic categorization, with graphs, analysis and interpretation.

The expression most commonly used to represent the treatment of data in a qualitative research is Content Analysis, according to Bardin. However, the expression means more than a technical procedure. It forms a historical part of a theoretical and practical search in the field of social investigations. It concerns research techniques that make it possible to make replicable and valid inferences about data from a given context, through specialized and scientific procedures. Content analysis starts from a foreground reading of the speeches, testimonies and documents, to reach a deeper level, going beyond the manifest meanings of the material. [8]

For quotations, the letter "P" was used, the initial of the name "participant", along with the numbering corresponding to the order of participation in the research.

RESULTS

Twenty-one open interviews were conducted with elderly hypertensive men belonging to UBS Centro Dr. Francisco Vitorino de Luna, from the city of Campos Sales-CE. Sampling of the population was done by saturation, with the collection phase being completed while the responses became repetitive.

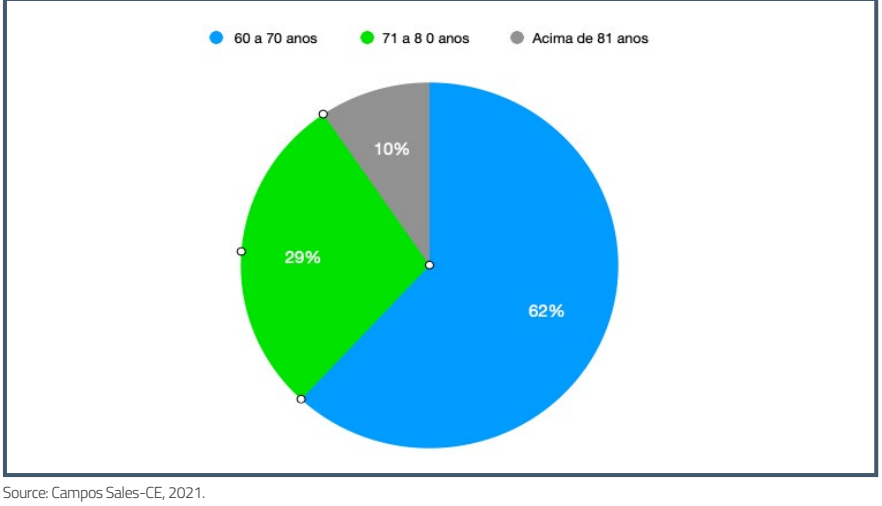
After closing the interviews, the content was separated according to the theme addressed, in order to guide the organization of the discussion.

For that, line-by-line reading was used, searching for simultaneous occurrence of facts, convergences, complementarities.

The figures below present the data collected for further discussion.

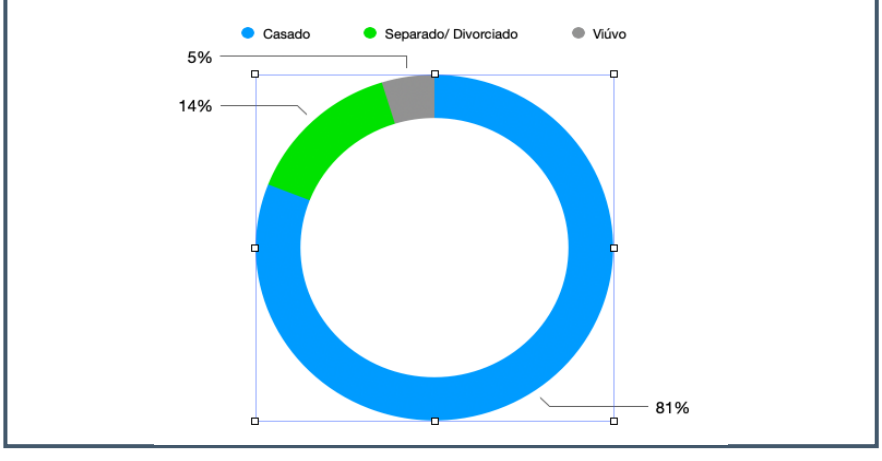
Participants were in the following age group: 13 (62%) aged between sixty and seventy years, 6 (29%) aged between seventy and one to eighty years, and 2 (10%) over eighty years. When referring to the age group, the data show that elderly men between 60 and 70 years old

Figure 01. Distribution of elderly hypertensive respondents according to age group, 2021.



Source: Campos Sales-CE, 2021.

Figure 02. Distribution of elderly hypertensive respondents according to marital status, 2021.



Source: Campos Sales-CE, 2021.

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represent 62% of the population participating in the study, which shows that they may be the most active and seek the PHC service. This finding suggests the need for more focused attention to this public in question, aiming at equitable care.

Regarding marital status, most of the 17 (81%) are married, 3 (14%) are separated and 1 (5%) is a widower

Regarding the number of children, 16 (76%) have 1 to 5 children, 3 (14%) have 5 to 10 children and 1 (5%) has more than 10 children, only 1 (5%) does not have a child .

Considering the level of education, there were 3 (14%) with no education, 13 (62%) with incomplete primary education, 1 (5%) with complete elementary education, 2 (10%) with complete secondary education and 2 (10%) with higher education.

As for monthly income, 15 received one minimum wage, 5 reported receiving one to two minimum wages, and 1 received two to three minimum wages.

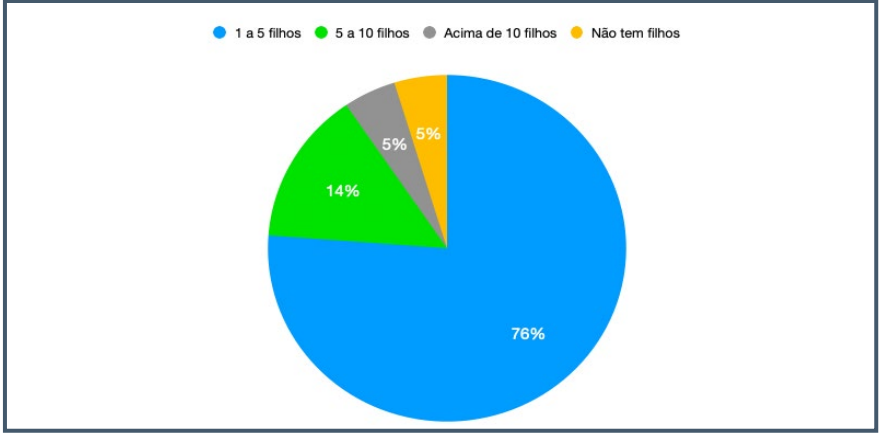
DISCUSSION

Characterization of the study population

These data show that most participants remain married. In the analysis of factors associated with greater frailty among the elderly, it is highlighted that not having a spouse or partner represents a risk factor. Married elderly men appear to be aging successfully. [7]

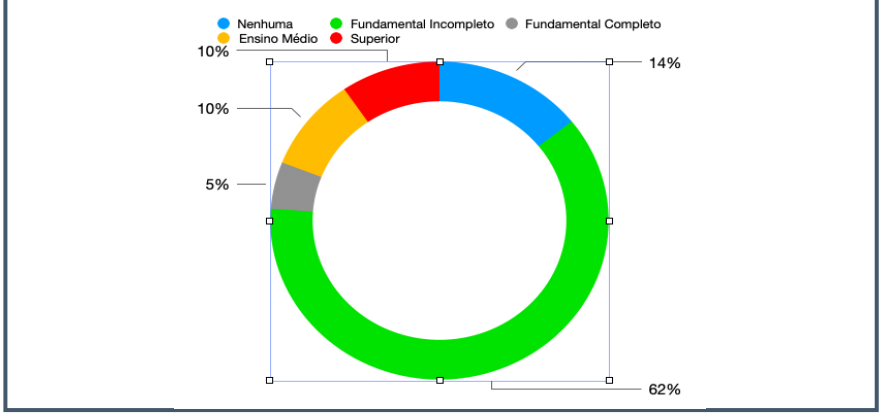
Regarding normative beliefs, positive social referents, children and wife, family, in general, are considered as motivational agents for taking antihypertensive medication. It is understood that having a social support network that involves the importance of treatment is substantial in the care and monitoring of the individual with hypertension, since social support and the value attributed to the family help the person with hypertension to follow the prescribed treatment, and should be considered when designing action strategies to im-

Figure 03. Distribution of hypertensive elderly regarding the number of children, 2021.



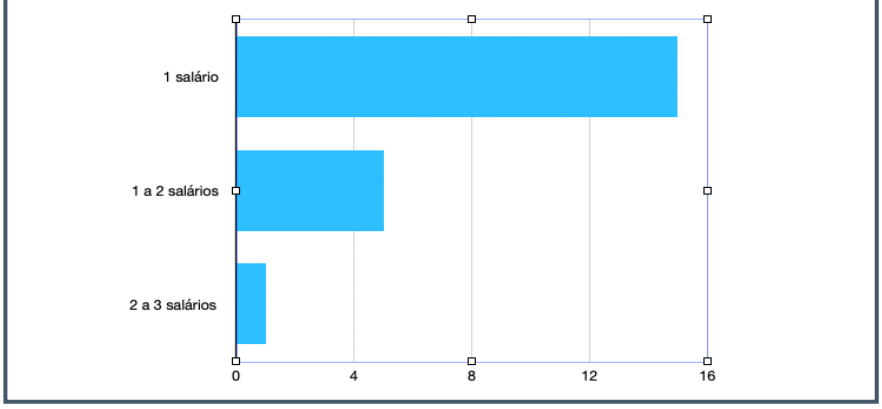
Source: Campos Sales-CE, 2021.

Figure 04. Distribution of hypertensive elderly interviewed according to education, 2021.



Source: Campos Sales-CE, 2021.

Figure 05. Distribution of elderly hypertensive respondents according to monthly income, 2021.



Source: Campos Sales-CE, 2021.

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prove adherence to antihypertensive treatment. Being close to the family can be seen as conditioning positive results in relation to adherence to antihypertensive drugs, since the family plays a motivating role in following the therapy. [8]

When comparing the perception of the severity of the disease and the levels of education, it was observed that patients with a higher level of education were also the most enlightened, as they perceived the disease as serious and incurable.

As for the predominance of low schooling in these patients, it is relevant that the approach be made in simple language and compatible with the degree of understanding. It should be noted that the family has a greater participation in the treatment and can express its knowledge, based on the principle that a higher level of education favors understanding about the disease and care, even because the education can be seen as a relevant contributor in the quest to win the hypertensive adherence to treatment.

There is a clear association between low education and a higher prevalence of chronic diseases, revealing the role of social inequalities in illness. In this sense, it should be noted that, in inverse proportion, higher education can potentially be the guiding principle for the prevention of chronic noncommunicable diseases (NCDs), since it can provide greater clarification about health promotion practices, disease prevention, in addition to greater access to services. [9]

Confirming the above, the low level of education presented by the elderly at risk of frailty and frail has a negative impact on the search for assistance and on self-care practices. Added to this, the few years of study or the lack of literacy suggest an unfavorable socioeconomic situation, resulting in social inequalities. Elderly people with low levels of education seek health services less frequently, as they have little or no knowledge about the need to access services. In addition, it is also strongly related to functional disability, cognitive impairment and risk of frailty in the elderly. This encourages reflection on care and management processes, in the search for quality and specific care for individual demands in PHC. [10]

Related to monthly income, this fact confirms that the study population is part of a social class devoid of significant financial resources, and dependent on the SUS. Poverty is one of the striking characteristics of the Brazilian elderly population, whose main source of income is retirement and pensions.

Of the participants interviewed, most reported living on a minimum wage to meet all the needs of the house. Few people were out of this reality. The low income of families living with SAH is an expressive number that can compromise its treatment, also because the treatment is related to food issues that are often not considered in this family budget.

Among the most common socioeconomic variables, schooling and income stand out. The lower the education and income, the greater the chance of having SAH. Studies indicate that both individual and macroeconomic socioeconomic characteristics are associated with a greater chance of having SAH in people and populations of lower socioeconomic status. They point out that individuals exposed to conditions of social and economic fragility, either individually or in the areas where they live, have a greater chance of developing SAH. However, they argue that the mechanisms underlying this association still need to be better explored. [11]

For this clientele, it is necessary to rethink the importance of improving strategies aimed at treating SAH, as they are mostly low-income people, who need more attention, better instructions, because they have a disease that needs to be controlled, to avoid complications or irreversible damage.

Knowledge of SAH and its treatment: "it gives anguish and anxiety, and then the blood pressure rises, the mistreatment that the person does to us..."

SAH is recognized as a highly prevalent disease, accompanied by a high risk of morbidity and mortality, which constitutes a serious public health problem, as it has a slow and silent evolution, making it difficult for subjects to perceive it. The question was asked about what they understand by SAH, and as for the answers, few were able to define it:

> *...high blood pressure...accumulated fat in the blood then comes high blood pressure... (P. 1).*
>
> *...causes drowsiness...headache ... (P. 5).*
>
> *...eating a lot of sugar, fat, worries, causes high blood pressure... (P.10).*
>
> *...exaggerated concern caused me to acquire this disease... (P. 17).*
>
> *...the pressure goes up and down... (P. 18).*
>
> *...yes, because when I have high blood pressure I feel a headache... (P. 19).*
>
> *...it gives anguish and anxiety, and then the blood pressure rises, the mistreatment that the person does to us generates anguish... (P. 20).*

It is noted that most participants did not know how to define SAH in terms of concepts that bear the biological aspect, but associate high blood pressure with the appearance of an unhealthy lifestyle, as well as a response not related to the definition, but to a conception that involves experiences accumulated in existence. Some relate concern, anxiety, and mistreatment, reports that demonstrate their state of life, with suffering and sadness in their eyes. While others approached their answers with the definition of the disease and replied:

> *...there is no control, it can cause*

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heart attack, stroke, it can cause any other kind of problem... (P. 2).

...uncontrolled pressure...never heard of curing the disease, there are only palliatives... (P.6).

...yes, it is a chronic disease... (P. 14).

SAH is a multifactorial clinical condition that is characterized by persistently high blood pressure (BP) levels. It may be associated with structural and/or functional changes in target organs and metabolic changes, which may lead to a high risk of fatal and non-fatal cardiovascular events. It has a high prevalence, low control rates and is one of the most important public health problems. This disease has been increasing in developing countries, because it is, in most cases, asymptomatic and due to the lack of information about its control by the population. [12]

The elderly have a poor or very poor perception of their own health, which becomes a warning about the repercussions of this potential marker for frailty. When positive, the self-perception of health indicates that the elderly have preserved autonomy, mobility and functional capacity, as well as the desire to remain active and independent in their daily activities, important conditions for the development of preventive practices for diseases. [10]

The high prevalence may be related to the various risk factors associated with this disease, which may be non-modifiable (age, gender and ethnicity) and modifiable (excess weight, excess salt and alcohol intake, sedentary lifestyle, smoking. The modifiable risk factors should be investigated in order to know which ones are more relevant in different populations, allowing interventions to modify the lifestyle of individuals. [12]

The diagnosis of a chronic disease implies important changes in the lives of people who have it. From there, patients begin to need comprehensive care, involving biological, social, economic and psychological aspects, leading to a perception of little control over their own lives. There is often a rejection of understanding by patients about their diseases, mainly related to the lack of knowledge about late complications, thus making it difficult for these individuals to adapt to treatment and change their lifestyle. Therefore, it is necessary to carry out simulation and training techniques for the promotion of self-care that promote concrete changes in the behavior of patients, in order to provide them with autonomy of care in relation to their illness. [9]

Changes in behavior, understanding of diseases and perception of adherence to treatment are individual conceptions, and it takes time for the person to assimilate the relevance of changes in attitudes and adhere to self-care in order to improve their quality of life (QoL). [13]

After a brief explanation of what SAH is, the question was asked about how they believe they will live with this disease, however few were able to mention the risks, but they have faith and trust in God, as illustrated by the report of some interviewees:

...you'll live with it for the rest of your life/ when you don't take the medication, your blood pressure goes up... (P. 1).

...controlling and moving forward with life, as God wants... (P. 3).

...God is in charge... (P. 12).

...take medication...until God wants it... (P. 16).

Some showed awareness about taking the medication:

...take the pill... (P. 4).

...taking medication from the health center, purely... (P. 10).

While others stated that in addition to the use of medication, they were aware that they should have some changes in their lifestyle, as reported:

...taking medicine and eating the right food... (P.7).

...taking the correct medication, eating better, not drinking or smoking... (P. 15).

...medication. If I don't take it, it gives me a headache... I need to eat properly and use the medicines correctly... (P. 17).

...using the medication and changing the diet, doing some physical activity... (P. 19).

...not being able to eat fat, avoid soda, sugar and salt... (P. 20).

Others mentioned being farmers and associated the increase in BP with the work performed, related to working hours and being overweight:

...well, take the medication. You just can't pick up weight... (P. 9).

...do not drink alcohol, do not smoke so as not to alter BP, take the correct medication, the right time, avoid heat, hot sun, do not work at these times, work until 10:00/10:30 am... avoid heavy material and work in the heat/ sun ... (P.2).

It is necessary to look at the social and epidemiological knowledge of the problems that affect or may affect these male rural workers, in order to think about effective educational measures to meet their claims. For the use of these active and dialogical approaches to health education, it is necessary to change the behavior of the professionals who are part of the PHC teams and, mainly, of

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the family health teams in the field. [14]

Differentiated care is needed for this population, often needy and unaware of their rights. Seek to look according to the needs presented and minimize the risk of injuries, providing a better quality of life.

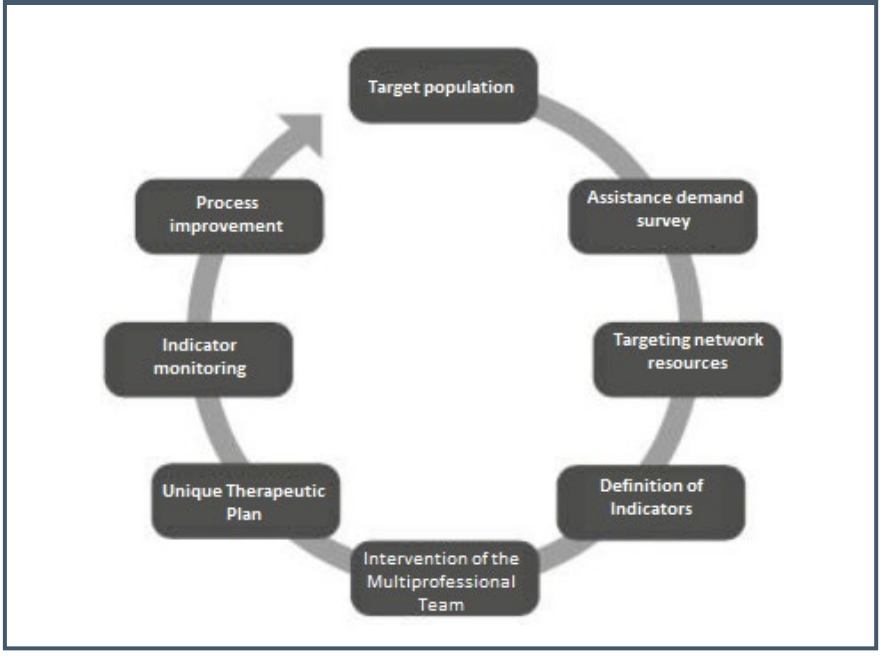
The organization of health care for the elderly is a category created to understand two different, yet complementary, aspects linked to the development of a care structure for the elderly population in the SUS. All health care organization strategies must aim to achieve universality and completeness of care for the elderly in the SUS. When we deal with the elderly population, we have to think about universal care as well as the creation of structures adapted to care for this age group.[15]

The aforementioned authors state that only with the existence of adequate equipment and flows to meet the needs of this population will it be possible to guarantee the quality of care. For this reason, the organization of care strategies represents one of the great challenges for managers in the search for alternatives that meet the specific demands of the elderly and their families. However, matrix support makes it possible to leverage network resources. From it, it is possible to survey the elderly in your coverage area according to the criteria of your interest, for example, by functional condition or underlying disease. This favors the planning and organization of service demands.

If this matrix support cycle were applied, we would have an assisted population, according to their specificities and needs, people with more education and potentially committed to their health. It is necessary to rethink and review the way to produce health and prevent diseases.

Old age is a phase of life that brings specificities to the implementation of social policies. Elderly people experience certain situations that can seriously harm their health and QoL. Intersectoral articulation, under certain circumstances,

Figura 06. Matrixing Cycle for Management



Source: ROMERO, D.,CASTANHEIRA, D, 2020, data adapted by the authors, 2021.

becomes imperative for effectively confronting these situations. Chronic conditions have become increasingly relevant in terms of morbidity and mortality in all countries of the world. [16]

NCDs constitute one of the biggest public health problems today and have generated a high number of premature deaths, loss of QoL (with a high degree of limitation and incapacity for activities of daily living), in addition to economic impacts for families, communities and society in general. NCDs are characterized by having a multiple etiology, many risk factors, long latency periods, prolonged course, non-infectious origin and also by being associated with functional impairments and disabilities. Its occurrence is greatly influenced by living conditions, by social inequalities, and is not just a result of lifestyles. NCDs still require a systematic approach to treatment, requiring new strategies from health services. [16]

CONCLUSION

The occurrence of SAH is greatly influenced by living conditions, by social inequalities, and is not just a result of lifestyles. NCDs still require a systematic approach to care and treatment, demanding new strategies from health services. The organization of care strategies by managers and other professionals represents the search for alternatives that meet the specific demands of their families. Matrix support makes it possible to leverage network resources, favoring the planning and organization of service demands.

Based on the information collected from the participants, with the majority in economically vulnerable conditions, low education, the need to implement health promotion is evident. Health professionals/management could follow more guiding paths of care, aiming at preventing and resolving possible problems: identifying and treating them, defining possible resolute ways and implementing it, setting goals and monitoring

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them. It is necessary to work on the capacity for reinvention, with new strategies to attract men to the health service, according to their needs and peculiarities, guaranteeing the longitudinality of care.

As changes in behavior, understanding about diseases and the perception of adherence to treatment are individual concepts, it takes time for people to assimilate the relevance of changes in attitudes and adhere to self-care in order to improve their QoL. However, it is necessary to intervene as soon as possible to promote health. As well as innovation in the care provided by the team to subsidize the matrix support according to the singularities of the service users.

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