

FACTORS ASSOCIATED TO TREATMENT ADHERENCE IN HYPERTENSIVE USERS

Fatores relacionados à adesão ao tratamento do usuário hipertenso

Factores relacionados a la adhesión al tratamiento del usuario hipertenso

Original Article

ABSTRACT

Objective: To describe the factors associated to treatment adherence in hypertensive users. **Methods:** A cross-sectional descriptive study with quantitative approach, developed in Fortaleza-CE, Brazil. The sample consisted of 400 hypertensive users. Data collection occurred from July to October 2010, through interview. Descriptive statistics was employed and data was represented in pictures. **Results:** Most respondents were women (269 - 67.2%); age ranged from 40 to 79 (390 - 97.5%). According to the interviewees, the conditions highlighted as favorable to treatment adherence were: regarding the user himself - 280 (70%) users reported the financial input to purchase food and medicines, and 172 (43%) stated the investment in self-care; the family - 78 (19.5%) users cited the encouragement to adherence and 78 (19.5%) were willing to reduce the financial responsibility for the family; the health team - 189 (49.5%) indicated freedom to verbalization, 168 (42.0%) cited resolving and human assistance and 115 (28.7%) users requested active listening; the health institution - 242 (60.5%) users opted for reducing the time in the waiting room for consultations and examinations. **Conclusion:** The favorable conditions for treatment adherence in hypertensive users were linked to the user himself, family, health team and the health institution, with evidence of interrelationship and interdependence.

Descriptors: Patient compliance; Hypertension; Primary Health Care.

RESUMO

Objetivo: Descrever os fatores relacionados à adesão ao tratamento do usuário hipertenso. **Métodos:** Estudo transversal descritivo, com abordagem quantitativa, desenvolvido em Fortaleza-CE, Brasil. A amostra foi constituída por 400 usuários hipertensos. A coleta de dados ocorreu entre os meses de julho e outubro de 2010, por meio de entrevista. Foi utilizada a estatística descritiva e os dados representados em quadros. **Resultados:** A maioria dos entrevistados consistia em mulheres (269 - 67,2%), com faixa etária entre 40 e 79 anos (390 - 97,5%). De acordo com os entrevistados, destacaram-se como condições favoráveis à adesão ao tratamento: em relação ao próprio usuário - 280 (70%) usuários indicaram o aporte de recursos financeiros para aquisição de alimentos e medicamentos, e 172 (43%) afirmaram o investimento no autocuidado; à família - 98 (24,5%) usuários declararam a ajuda financeira para aquisição da medicação anti-hipertensiva, 78 (19,5%) citaram o encorajamento na adesão e 78 (19,5%) desejaram a redução da responsabilidade financeira com a família; à equipe de saúde - 189 (49,5%) usuários indicaram liberdade para verbalização, 168 (42%) citaram atendimento resolutivo e humano e 115 (28,7%) solicitaram escuta ativa; à instituição de saúde - 242 (60,5%) usuários optaram pela redução do tempo na sala de espera para consulta e realização de exames. **Conclusão:** As condições favoráveis à adesão do usuário hipertenso ao tratamento estão vinculadas ao próprio usuário, à família, à equipe de saúde e à instituição de saúde, havendo uma evidência de inter-relação e interdependência.

Descritores: Cooperação do Paciente; Hipertensão; Atenção Primária à Saúde.

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RESUMEN

Objetivo: Describir los factores relacionados a la adhesión al tratamiento del usuario hipertenso. **Métodos:** Estudio trasversal, descriptivo, con abordaje cuantitativo, desarrollado en Fortaleza-CE, Brasil. La muestra fue constituida de 400 usuarios hipertensos. La recogida de datos se dio entre los meses de julio y octubre de 2010 a través de entrevista. Fue utilizada la estadística descriptiva y los datos fueron representados en cuadros. **Resultados:** La mayoría de los entrevistados eran mujeres (269 – 67,2%), en la franja etaria de 40 y 79 años (390 – 97,5%). Conforme los entrevistados, se destacaron como condiciones favorables a la adhesión al tratamiento: en relación al propio usuario - 280 (70%) usuarios indicaron la contribución de recursos financieros para la adquisición de alimentos y medicamentos, y 172 (43%) afirmaron la inversión en el autocuidado; la familia - 98 (24,5%) usuarios declararon la ayuda financiera para la medicación antihipertensiva, 78 (19,5%) relataron el incentivo a la adhesión y 78 (19,5%) desearon la reducción de la responsabilidad financiera con la familia; el equipo de salud - 189 (49,5%) usuarios indicaron libertad para verbalización, 168 (42%) citaron atención resolutiva y humana y 115 (28,7%) solicitaron escucha activa; la institución de salud - 242 (60,5%) han elegido la reducción del tiempo de espera para la consulta y realización de pruebas. **Conclusión:** Las condiciones favorables a la adhesión del usuario hipertenso al tratamiento están vinculadas al propio usuario, la familia, el equipo de salud y la institución de salud, con evidencia de inter-relación interdependencia.

Descriptor: Cooperación del Paciente; Hipertensión; Atención Primaria de Salud.

INTRODUCTION

Systemic arterial hypertension (SAH) is a risk factor for diseases resulting from atherosclerosis and thrombosis, which are externalized predominantly through cardiac, cerebral, peripheral vascular and kidney ischemic impairment. It has been responsible for approximately 25% of the multifactorial etiology of ischemic heart disease and 40% of the stroke etiology, being the cause of hypertensive heart disease⁽¹⁾.

In 2000, the worldwide prevalence of SAH was 26.4%, corresponding to 972 million people. In the United States, there are about 50 million hypertensive individuals. In Brazil, the Brazilian Society of Hypertension (SBH) estimates there are 30 million (30% of the adult population). Of people over 60 years, 60% present hypertension. It is assumed that, worldwide, there is about a billion hypertensive patients⁽²⁾.

From the criteria currently used to diagnose hypertension (systolic blood pressure - BP \geq 135 mmHg and/or diastolic BP \geq 85 mmHg)⁽²⁾, the prevalence rates in the urban adult population in selected studies range from 22.3%

to 44%, with estimated values between 15% and 47.8% among men and between 15% and 41.1% among women. In Brazilian cities like Araraquara-SP and São Paulo-SP, in 1990, the rates found were 43% and 22%, respectively; in Piracicaba-SP, in 1991, 33%; Porto Alegre-RS, in 1994, 26%; and Cotia-RS in 1997, 44%⁽²⁾.

In Ceará, between the months of January and May 2012 4,617 new hypertensive users were registered. Of these, 1,543 (33.4%) were male and 3,074 (66.6%) females. In the same period, in Fortaleza-CE, there were 203 users, being 53 (26.1%) men and 150 (73.9%) women⁽³⁾.

Constitutional risk factors of SAH include: a) the age, the prevalence of which is around 7% for children, 20% for adults and 65% for the elderly; b) sex, since the woman until menopause is less affected than the man, due to the production of estrogen, which exerts a protective function on the female cardiovascular system; although she is equal to man from this stage of life on; c) color, where there is a predominance in black people; and d) family history, which contributes to the development of morbidity, when coupled with other factors⁽⁴⁾.

The lifestyle factors contributing to the onset of SAH include: excessive consumption of salt and animal fat; obesity, one potential factor in the disease development; stress, due to excessive stimulation of the sympathetic nervous system, increasing blood pressure levels; smoking, due to increased BP by the presence of nicotine; alcohol, which acts in the myocardium; sedentary lifestyle, associated with the current lifestyle of the population; and the use of oral contraceptives, through the action on the cardiovascular system of women⁽⁴⁾.

In outpatient care for hypertensive users, it has been observed that lack of adherence to treatment is associated with acquisition costs, discomforts and complexity of the medicinal schemes, besides the difficult access to the health system.

Adherence to treatment is a multifactorial process based on a partnership between those who care and who is provided care; it regards the frequency, constancy and perseverance towards care seeking health. Therefore, the link between professional and patient is a structuring factor and consolidating of the process, therefore, it should be considered⁽⁵⁾.

The issue of adherence is complex, since several factors are associated with the patient (sex, age, ethnicity, marital status, educational and socioeconomic status), disease (chronicity, absence of symptoms); beliefs, cultural and living habits (perception of the seriousness of the problem, lack of knowledge, experience with the disease, family background, concept of health and disease, self-esteem); treatment (cost, side effects, complex schemes, quality of

life); the institution (health policy, access, distance, waiting and attendance time); and the relationship with the health care team (inadequate involvement and relationship)⁽⁶⁾.

Non-adherence to treatment may be a result of the side effects of antihypertensive drugs, financial barriers, lack of motivation of the patient to treat an asymptomatic disease, the length of treatment (for life), the influence on quality of life, inappropriate relationship with the healthcare team, among other factors⁽⁷⁾.

Thus, adherence includes therapeutic and educational factors related to patients, aspects relating the recognition and acceptance of its health conditions, an active adaptation to these conditions, the identification of risk factors in lifestyle, the cultivation of habits and attitudes promoters of quality of life and the development of awareness for self-care. Factors related to the professional(s) are also considered, comprising health actions focused on the individual, not only on procedures, with guidance, information, adequacy of treatment regimens to the patient's lifestyle, clarification, social and emotional support⁽⁵⁾.

In this perspective for action, the welcoming attitude of the care-giving professional supports the patient to new attitudes towards the illness, thus the medicine becomes merely another therapeutic resource in health promotion. There are also factors related to the health institution, the purpose of which is to promote and encourage actions that contribute to the individuals involved in their walk towards the effectiveness and quality of treatment⁽⁵⁾.

It can be said that there is almost a social requirement for changes in the process of training professionals, able to provide comprehensive and humanized care to people, who work in teams and know how to make decisions considering not only the individual clinical situation, but the context patients live in, the available resources and the most effective measures⁽⁸⁾.

Based on the issue and the determinants of adherence, beyond the user's responsibility for his treatment, a question is made: in the user's opinion, how can the institution, the family, the health team and himself favor the adherence to SAH treatment? Upon this questioning, this study was chosen with the aim of describing the factors related to treatment adherence in hypertensive patients.

METHODS

Cross-sectional study with a quantitative approach, developed in a Family Health Center (*Centro de Saúde da Família - CSF*) of the Regional Executive Office VI (*Secretaria Executiva Regional VI - SER VI*), in Fortaleza-CE.

The study population comprised 1,600 hypertensive patients enrolled in the CSF and registered in Hiperdia.

The sample consisted of 400 users older than 20 years who agreed to participate, regardless of age, sex, race, level of education, marital status or family income. It is noteworthy that the sample size calculation was based on the prevalence of SAH in Brazil, which was around 25%⁽²⁾.

The data was collected during the months of July and October 2010, using a structured interview, whose script contained sociodemographic data and that related to the favorable conditions for adherence to the treatment of hypertensive patients. Data was then organized in the Statistical Package for Social Science (SPSS), represented on charts and analyzed using absolute frequency.

The research was conducted in accordance with Resolution 196/96 of the National Research Ethics Committee (*Comissão Nacional de Ética em Pesquisa - CONEP*)⁽⁹⁾. Participants were instructed regarding anonymous and that they could withdraw their consent anytime they wished. Data was collected after signature of the Free and Informed Consent Form and the issue of a favorable opinion, number 04-429/2010, by the Research Ethics Committee of the Hospital of Messejana/MS/SUS/SESA, in Fortaleza-CE.

RESULTS

To enable the analysis, the data was grouped into the users' sociodemographic characteristics of descriptions of favorable conditions for adherence of hypertensive patients to the treatment.

On the sociodemographic characterization, according to Chart I, it is seen that the majority of respondents were female (269 - 67.2%), brown-skinned (219 - 54.7%) and aged between 40 and 79 years (390 - 97.5%). It is noteworthy the presence of 54 (13.5%) black and 228 (57.2%) individuals with family history of SAH. Data also revealed 10 (2.5%) users aged between 20 and 39 years, with predominance among women.

Among the users, 255 (63.7%) were literate and/or had attended primary school, and 79 (19.7%) were illiterate. Of the respondents, 199 (49.7%) reported having monthly income of one to two minimum wages and 142 (35.5%) had family income lower than that. As for the occupation, 194 (48.5%) were retired, 75 (18.7%) were occupied with household and the others (32.7%) reported working activities such as sewing, construction, carpentry, housework and crafts.

It was found that 289 (72.2%) respondents came from Fortaleza-CE, 97 (24.2%) of which were born in the capital, while 192 (48%) were from other cities of Ceará. Among the 111 (72.2%) residing in Fortaleza, 97 (24.2%) were

native and 14 (3.5%) were born in Fortaleza. The Catholic religion prevailed, reported by 311 (77.7%) users. It was also identified that 216 (54.0%) were married, 331 (82.7%) lived in their own house and 150 (37.5%) lived with spouse and/or children.

Regarding the descriptions of favorable conditions for hypertensive patients' adherence to treatment, in the item 'the user's own conditions', Chart II shows that 280 (70%) users indicated the contribution of sufficient financial resources to purchase food, medicine, and other conditions necessary for well-being; 128 (32%) pointed a health insurance plan, because it would eliminate the difficulties in accessing the NHS (*SUS*), and 113 (28.2%) indicated the residence in Fortaleza-CE, due to better conditions of healthcare.

For 172 (43%) users, it would be the indispensable the investment in self-care; 138 (34.5%) highlighted the awareness about SAH risks for health; 88 (22%) pointed

the search for orientations on the treatment with the health team; and 72 (18%) emphasized the attention to the orientation provided.

Among the conditions for adherence to treatment, those inherent to the emotional dimension were raised by the women, namely: fighting depression, reducing concerns related to children's and spouse's alcoholism (128 - 2.0%), financial difficulties and family conflicts; and individual residence (39 - 9.7%).

According to other users, adherence to treatment is contingent upon the work activities, as 98 (24.5%) reported returning to work, since they were removed due to retirement and unemployment, 60 (15%) pointed a reduction of work activities in households.

With regard to the conditions inherent to the family, in Chart II are the suggestions by users: 95 (23.7%) reported dedication, 86 (21.5%) wished understanding and 78 (19.5%) cited the encouragement for compliance.

Chart I - Distribution of hypertensive users, according to the sociodemographic characteristics. Fortaleza-CE, 2010. n = 400

Sociodemographic characteristics							
		f	%			f	%
Age range (years)	20-39	10	2.5	Place of birth	Fortaleza-CE	111	27.8
	40-59	173	43.2		OC ³	289	72.2
	60 or above	217	54.3	Origin	Fortaleza-CE	289	72.2
Sex	Male	131	32.8		OC ³	111	27.8
	Female	269	67.2	Religion	Catholicism	311	77.7
Color	Brown	219	54.7		rotestantism	67	16.7
	White	127	31.7		Not informed	22	5.5
	Black	54	13.5	Housing conditions	Rented	45	11.5
Monthly income ¹	Below 1	142	35.5		Own	331	82.5
	1-2	199	49.7		Others ⁴	24	6.0
	Above 2	59	14.8	Marital status	Married	216	54.0
Literacy	Illiterate	79	19.7		Single	42	10.5
	Literate	148	37.0		Divorced	45	11.2
Primary education	107	26.7		Household partner	Widow	74	18.5
Secondary education	54	13.0			Stable union	23	5.7
Higher education	12	3.0			Son	67	16.7
Occupation	Retired	194	48.5		Spouse	39	9.7
Housework	99	24.7			Spouse and son	150	37.5
Others ²	107	26.8			Others ⁵	144	36.0

¹ In minimum wages (R\$ 510,00). ² Domestic work, construction, carpentry, sewing, crafts; ³ Other cities of Ceará. ⁴ Nursing home, workplace, residence of family members and acquaintances; ⁵ Nursing home residents, employers, acquaintances domestic.

Chart II – Distribution of hypertensive users according to adherence factors to treatment, regarding the user himself, the family, the health team and the health institution. Fortaleza-CE, 2010. n = 400

User	f	%	Family	f	%	Health team	f	%	Health institution	f	%
Enough Financial resource	280	70.0	Reduction of worries	160	40.0	Punctuality	225	56.2	Reduction of time in the waiting room	242	60.5
Self-care investment	172	43.0	Banishment of alcoholism in family members	128	32.0	Legible medical prescriptions	201	50.2	Efficacy in scheduling and performing exams	204	51.0
Consciousness of SAH risks	138	34.5	Nearby household	113	28.2	Freedom to verbalization	189	49.5	Agility in assistance	198	49.5
Acquisition of health insurance	128	32.0	Acquisition of medication	98	24.5	Delivery of exams' results	174	43.5	Replacement of an absent professional	188	47.0
Household in Fortaleza-CE	113	28.2	Dedication	95	23.7	Humanized and resolute assistance	168	42.0	Provision of the whole medication	176	44.0
Fight against depression	112	28.0	Comprehension	86	21.5	Banishment of authoritarianism	135	33.7	Reduction of interval between appointments	169	42.2
Return to work	98	24.5	Motivation for adherence	78	19.5	Reference to professionals	121	30.2	Demand for doctors' punctuality	98	24.5
Search for orientation by the health team	88	22.0	Reduction of financial responsibility	78	19.5	Provision of orientations	116	29.0	Reduction of changes in medications	98	24.5
Attention to orientations received	72	18.0	Acceptance of individualized household	39	9.7	Active listening	115	28.7	Priority in assistance	89	22.2
Reduction of labor activities	60	15.0	Household with family members	16	4.0	Boost to self-esteem	98	24.5	Increase in number of professionals	88	22.0
Reduction of worries	52	13	Nothing to add	141	35.2	Nothing to add	71	10.2	Qualification of workers	87	21.7
Individualized household	45	11.2	Did not inform	99	27.4	Did not inform	128	32.0	Flexibility in scheduling appointments and exams	87	21.7
Nothing to add	68	17.0						Stimulation of the ombudsman	86	21.5	
Did not inform	52	13.0						Nothing to add	56	14.0	
								Did not inform	102	25.5	

Other users have made references to cohabitation: 39 (9.7%) aspired family members to accept that they were living alone, for the purposes of peace and rest, although 113 (28.2%) would rather live close to family members and 16 (4%) lived with the family.

Ninety-eight (24.5%) hypertensive patients declared financial assistance for the acquisition of antihypertensive medication, since they did not receive it regularly, and 78 (19.5%) wished to reduce the financial responsibility before the family, by transferring part of it to the sons, since they were financially independent and living with parents. For 128 (32%) users, the abolition of alcoholism among family members significantly contributes to treatment adherence.

Regarding the conditions relating to health staff, chart II reveals the suggestions from those users on the relationship with the healthcare team, as follows: 189 (49.5%) indicated freedom to verbalization, 174 (43.5%) focused on the provision and explanation of test results, 168 (42%) cited resolute and human assistance, 135 (33.7%) mentioned the abolition of authoritarianism, 121 (30.2%) the doctor's referral to other professionals, 115 (28.7%) requested active listening and 98 (24.5%) suggested behaviors that elevate self-esteem. In addition, 225 (56.2%) reported the physicians' punctuality and attendance, and 201 (50.2%) suggested the legibility of prescriptions.

Chart II also reveals the strict conditions of the health institution for hypertensive patients' adherence to treatment, which were linked to assistance, human resources and pharmaceutical support.

On the assistance, 242 (60.5%) users indicated the reduction in the waiting time for consultation and examinations, 204 (51%) spoke about the effectiveness of the appointments and the examinations, 198 (49.5%) mentioned the agility of the service, 169 (42.2%) cited the reduction in the interval between visits, 89 (22.2%) emphasized the establishment of priorities in care, 87 (21.7%) pointed the flexibility in scheduling the appointments and tests and 86 (21.5%) requested boosting the ombudsman.

About the human resources, 188 (47%) hypertensive patients suggested the doctor's replacement if absent to practice, 98 (24.5%) demanded punctuality of doctors, 88 (22%) indicated an increase in the number of professionals and 87 (21.7%) suggested the qualification of workers involved in care.

As for the pharmaceutical support, 176 (44%) requested total and regular provision of the prescribed medicine, and 98 (24.5%) mentioned reducing the changes in the medication.

DISCUSSION

Regarding the biosocial characteristics of the investigated users, the fact the majority is female may indicate that women are more concerned with their health, frequent more the health institutions and are more participative than male patients⁽¹⁰⁾. The predominance of women in the population seems to be due to men's increased mortality rate and to the fact that women's life expectancy is higher.

According to data from the census conducted in Brazil in 2000, the women's life expectancy is higher (72.6 years) than men's (64.8 years). The same is true for life expectancy at age 60, which is 19.4 years among women and 16 years for men⁽¹¹⁾. In Ceará, the numbers are smaller, however, women also have longer life expectancy (69.7 years) than men (63.1 years), as well as life expectancy at 60 years, that is 18 years for them and 15 for men.

The color also deserves to be evaluated since hypertensive blacks and browns were less adherent to consultations and had lower blood pressure control than whites⁽¹⁰⁾. The predominance of browns in the present study can be attributed mainly to the large existing miscegenation in Brazil. In Fortaleza, according to IBGE data, browns represent 55.1% of the population, and 2.8% are black⁽¹¹⁾.

Socioeconomic differences also stand out, as SAH features higher frequency among less favored economic classes, with indicators of low education and income, and poor access to health services and medicines⁽¹⁰⁾. These aspects corroborate the findings of this study and demonstrate these people are somewhat marginalized regarding access to school, significantly the female patients.

Low educational level is another factor pointed as compromising the levels of adherence to treatment, since the patient has difficulties to read and follow the medical prescription⁽¹²⁾. The prevalence of hypertension is inversely proportional to literacy and income, that is, the higher the level of education and economic capacity, the lower the incidence, as a result of better health care⁽¹¹⁾.

In the current study, place of birth and origin are directly related to socioeconomic status. People with underprivileged conditions were born in the countryside, and have possibly migrated to the capital with the view of improving their lives in relation to employment, housing and health.

A study revealed that the having a partner, as expressed by the marital status, can be a facilitator in the process of treatment of hypertensive patients⁽¹⁰⁾. Individuals who share experiences with their spouses and get their support can

have better participation in the treatment follow-up. On the other hand, those who do not live with a spouse or live with children and/or others present lower adherence to the therapeutic scheme. This can be attributed to the lack of stimulus for the hypertensive individual to follow treatment or to the suitability he is required to please other family members⁽¹³⁾.

Therefore, it can be seen that the grievance must be faced by all. If the family is included, changing the habits of life becomes easier, not to mention that it represents prevention of the hereditary factors. According to the participants, the family's contribution in adherence to treatment begins with the adoption of healthy habits, emotional and financial support.

The *SUS* establishes a public health policy that aims at comprehensiveness, universality, increased equity, incorporation of new technologies and specialization of knowledge. Although the expenses on drugs represent a large part of the investments in public health in countries like Brazil, free distribution of medicines does not cover the current needs, despite the great advances in this regard, as in the antihypertensive therapy. With regard to its guiding principles and decentralization of care and management, *SUS* still faces difficulty in promoting quality to the user's health⁽¹²⁾.

For the clientele to include that conduct in its daily life, it is imperative that the health team act in a comprehensive and interconnected way, through the development of health education strategies, aimed at raising awareness about the pursuit and maintenance of health.

The users' monitoring by the health professionals, intending to prevent complications and achieve a better quality of life, is one of the Ministry of Health's strategies for programs addressed at monitoring non-transmissible chronic diseases in primary care and it should be emphasized not only for the importance of pharmacological treatment, but also due to changes in lifestyle, guided by educational strategies for the empowerment of users⁽¹⁴⁾.

The effectiveness of the health team participation in monitoring the hypertensive person, in a systematic and comprehensive way, involves psycho-emotional aspect, providing guidance and clarification of doubts on the prevention and control of health problems, resulting in treatment adherence. Health education is essential, since it is not possible to achieve adequate control of blood pressure if the user is not advised of the principles that underlie the treatment. Therefore, the active participation of the individual is the only effective solution in controlling the disease and preventing its complications⁽¹⁵⁾.

SAH has an asymptomatic onset but, with time, demands arise from the disease and its treatment, and

some kind of disability might occur, such as: physical (eliminatory, sensory, motor); cognitive, like impaired orientation, reasoning and decision-making; social, like the physical and financial dependence on the family and changes in performance of one's role; and psychological, with occurrence of low self-esteem, motivational deficits, depression, anxiety, aggression, denial of illness etc.⁽¹⁶⁾

Considering these various aspects of SAH, the cognitive-behavioral referential has worked with two categories of intervention: a) behavioral methods, which aim at a direct action on the BP or physiological process that acts on its regulation, such as relaxation, biofeedback, hypnosis and autogenic training, and b) the psychotherapeutic methods, without a defined structure or specificity, aiming to influence the responses before the foci of tensions and modify the emotional status involved in this process, so that it indirectly favors the reduction of pressure⁽¹⁶⁾.

The return to work activities brings self-determination and independence to the user. It can function as a search for autonomy and meaning in life. Ludic, work-related, cultural and/or religious activities are very useful, allowing the individual the exploration of his potential by promoting the prevention, control and treatment of psychosocial disorders and even the adherence to antihypertensive treatment⁽¹⁷⁾. The benefits cited justify the suggestion of respondents about returning to work. Furthermore, changes of roles within the family may occur, which will possibly influence in a positive way the adherence of the hypertensive individual to treatment.

The family is highly relevant in the acquisition of habits and changes in lifestyle, and is therefore of great importance in the search for the client's adherence to treatment⁽¹⁸⁾. It is the first source of support, where their members turn to for solving problems, whether it is a simple meal preparation, a leisure modality, the routine of consultations or the medication use. Given that, the family must be closely involved in the treatment of SAH.

Care implemented by the family is aimed at preserving the lives of its members, with the advantage of being performed in a manner appropriate to their possibilities, their cultural patterns, particular needs and conditions of the environment they live in⁽¹⁹⁾. It assumes, therefore, a significant share of responsibility in the provision of healthcare to its members, especially regarding the chronic patient⁽⁴⁾.

The care provided by the family to the patient features obstacles, but they are transposed with love, dedication, solidarity and faith. Knowledge about the disease is revealed in the everyday life, showing how the disease is characterized, what causes it, its consequences and the financial impact of treatment, being required of health

professionals an integral perception of the patient in the family context⁽²⁰⁾.

Addictions in the family, such as the alcoholism, contribute to increased stress and concerns, bringing serious problems to the members who are suffering from hypertension⁽²¹⁾. The alcohol in excessive use relates to higher cardiovascular mortality. Somehow, this fact confirms the user's opinion that admits the negative impact of alcoholism practiced by family members on the adherence to treatment.

One of the problems highlighted by the hypertensive users in the present study is the lack of welcoming approach, patience and dialogue on the part of health professionals, indicating a deficiency in humanized assistance on the health team. Due to the clinical characteristics of SAH, to gain hypertensive people's compliance to the proposed therapeutic schemes requires dedication and time for the team to adequately inform and guide⁽²²⁾.

It is up to the health care team to encourage and educate the user, informing him clearly the clinical significance and prognosis of his disease. The bond is a consequence of a closer relationship between the user and the health team⁽²²⁾.

According to the Charter of Rights of Users of Healthcare⁽²³⁾, therapeutic prescriptions must contain: a) generic name of prescribed substances, b) clearly stating the posology, with dosage c) printed, typewritten, typed or in legible handwriting d) texts without codes or abbreviations, e) legible name of the professional and their registration number in the organ of control and regulation of the profession; f) date and the professional's signature, ensuring that citizens have adequate and effective treatment to their problem, aiming to improve the quality of services provided. Lack of clarity in prescriptions may favor non-adherence, and most respondents cited this fact.

The consolidation of the National Humanization Policy (*Política Nacional de Humanização - PNH*) focuses on four specific benchmarks: 1) queues and waiting time will be reduced, with increased access, friendly and resolving service based on risk criteria, 2) every user of SUS will know who are the professionals who care for their health and health services are responsible for their territorial reference, 3) health units will ensure the user the information, the right to have a person of his social network (at free choice) by his side and all other rights in the users' code of SUS; 4) health units will ensure participatory management to its employees and users, as well as continuing education for workers⁽²³⁾.

The simplification of the therapeutic schemes, reducing the frequency of medication intake, increases adherence to antihypertensive treatment. Furthermore, high doses of drugs can increase the incidence of adverse reactions. Thus, the use of two drugs in one formulation is a determining factor for a higher treatment adherence⁽²⁴⁾.

Interventions that increase the patient's motivation and involve multidisciplinary training, combined with measures to ensure patient's access to hypotensive medication, seem promising. The role of the physician is to maintain constant vigilance of any adverse reactions to antihypertensive drugs, using criteria based on the clinical epidemiology and outcomes of well-designed clinical studies for selection and individualization of the best drug for a particular patient⁽²⁴⁾.

The practice of pharmaceutical care is extremely important and requires knowledge of therapeutic and antihypertensive agents in order to be able to identify, prevent and resolve drug-related problems, increase the knowledge that patients should have about the disease and medication, favoring adherence to treatment, with the ultimate goal of better controlling BP⁽²⁵⁾.

CONCLUSION

From the viewpoint of hypertensive users, the conditions favorable to treatment adherence are linked to himself, the family, the healthcare team and the health institution. In this link, there is evidence of inter-relationship and interdependence.

It is also noted the direct relationship between the duties of the health team and managers towards the users and families, and their responsibility in treatment adherence, as well as in healthcare in general. This fact raises the core principles (rights and duties) supporting the Chart of Rights of the SUS users (*Carta dos Direitos dos Usuários do SUS - CDUS*).

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