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The meaning of being hypertensive from the experience of users accompanied by the Family Health Strategy

O significado de ser hipertenso a partir da experiência de usuários acompanhados pela Estratégia de Saúde da Família

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Abstract

Objective: This study aimed to understand the meaning of being hypertensive from the perspective of users regarding the diagnosis and treatment of systemic arterial hypertension (SAH). **Methods:** This qualitative study included 12 patients with SAH accompanied by a Family Health team. Data collection occurred using interviews with questions related to the objective of the study. The interviews were fully transcribed and subjected to content analysis in the thematic mode. **Results:** Patients were mostly female, aged between 40 and 60 years, married, with an income of up to one minimum wage, and up to eight years of education. In the thematic analysis, the main axes were identified as the experience of being hypertensive and reception and health care. The patients did not know the meaning of having SAH, as well as its consequences and severity. They believe that changes in routine after diagnosis linked to healthy eating influenced the reduction of the symptoms. In addition, reception contributed to the organization of care based on the identification of the needs of the patients through the involvement of the health team, users, and family members. **Conclusion:** The study showed that the perception of users about the experience of being hypertensive is related to the lack of knowledge about the disease and its forms of treatment, highlighting the need to strengthen the reception in basic health units and the development of actions to promote health and improve the quality of life of this population.

Keywords: Chronic diseases; Family Health Strategy; Primary health care; Systemic arterial hypertension.

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Resumo

Objetivo: Compreender o significado de ser hipertenso a partir do sentido dado pelos pacientes ao diagnóstico e tratamento para hipertensão arterial sistêmica. **Métodos:** Estudo de abordagem qualitativa, realizado com 12 hipertensos, acompanhados por uma equipe de Saúde da Família. A coleta de dados ocorreu por meio de entrevista com questões norteadoras direcionadas para o objetivo do estudo. As entrevistas foram gravadas, transcritas e submetidas à análise de conteúdo na modalidade temática. **Resultados:** Os participantes do estudo eram, na maioria, do sexo feminino, entre 40 e 60 anos de idade, casados, com renda de até um salário mínimo e com até oito anos de estudo. Na análise temática das entrevistas, foram identificados como eixos principais a experiência de ser hipertenso e acolhimento e atenção à saúde. Foi notório que os participantes não sabiam ao certo o significado de ser portador de hipertensão arterial sistêmica, assim como suas consequências e gravidade. Eles acreditavam que mudanças na rotina após o diagnóstico atreladas à alimentação saudável tinham influência na minimização dos sintomas. Foi identificado que o acolhimento contribui para a organização do processo de cuidado a partir da identificação das necessidades do paciente, por meio do envolvimento da equipe de saúde, usuários e familiares. **Conclusão:** O estudo evidenciou que a percepção dos usuários sobre a experiência de ser hipertenso está relacionada à falta de conhecimento sobre a doença e suas formas de tratamento, sendo importantes fortelecer o acolhimento nas Unidades Básicas de Saúde e desenvolver ações de promoção da saúde e melhoria da qualidade de vida dessa população.

Palavras-chave: Atenção Primária à Saúde; Doenças crônicas; Estratégia de Saúde da Família; Hipertensão arterial sistêmica.

INTRODUCTION

The Family Health Strategy (FHS) is considered an expansion and qualification strategy that aims to strengthen primary health care (PHC) using health promotion and disease prevention actions, favoring the quality of life of patients, families, and communities[1]. Although the FHS enables the user to access the Brazilian Unified Health System (SUS), gaps need to be improved to enhance the quality and resolvability of public health services[2].

In PHC, chronic non-communicable diseases (NCDs) represent a major public health problem and one of the main causes for seeking health services[3,4]. Among them is systemic arterial hypertension (SAH), a chronic disease characterized by high blood pressure caused by genetic, environmental, and lifestyle factors. SAH is one of the main causes of morbidity and mortality, and it is a basic disease for other comorbidities, such as atherosclerosis, stroke, and cardiovascular diseases[5,6].

In Brazil, SAH affects more than 30 million people, with a higher prevalence in older adults[5]. Social determinants strongly contribute to this increased prevalence, including social inequalities, differences in access to goods and services, low education, and misinformation[7,8]. The increase of patients with SAH in the country should be considered relevant, as this pathology increases the demand for health services, generating high costs for health systems[5].

Cases of SAH are recommended to be treated in PHC, requiring the service to be resolute and effective. Thus, patients with SAH must access the basic health units (BHU) to improve their quality of care and follow-up, ensuring diagnosis, treatment, and care by the multidisciplinary team to promote greater adherence and treatment control[8,11,12].

The FHS plays an important role in monitoring SAH, contributing to the awareness of patients and their families about coping with this disease[11,12]. Thus, new management measures are important to improve health teams and adequately elaborate clinical, therapeutic, and educational intervention strategies for patients with SAH[5].

Studies on this theme are essential to guide healthcare professionals on attitudes and strategies for dealing with these patients. Therefore, this study aimed to understand the meaning of being hypertensive based on the perspective of patients regarding the diagnosis and treatment of SAH.

METHODS

This qualitative study was conducted in a BHU (Olinda, Pernambuco), which is comprised of two family health teams that accompany 12,000 patients registered in a community that presents areas of difficult access and lack of basic sanitation. The population has low purchasing power, and the main income comes from the social programs of the federal government.

This study included 12 patients with SAH who were monitored by the family health team and whose diagnosis was recorded in the medical record; selection was performed using simple random sampling. The inclusion criteria encompassed patients with SAH registered in the medical record, aged ≥ 18 years, who were followed up for at least six months by the BHU. Those residing outside the BHU coverage area were excluded.

Data collection was conducted by the researchers from November to December of 2022 using a semi-structured script divided into two parts: the first included sociodemographic characterization (age, sex, marital status, skin color, income, and years of education), lifestyle (smoking, alcohol consumption, and other drug intake), and clinical aspects (pathologies and comorbidities). The second part included questions directed to the objective of the study, based on the two main axes: “The experience of being hypertensive” and “Reception and health care”.

To ensure the anonymity of the patients, they were named by the letter U (user) followed by the number of the order in which they were interviewed. The interviews were recorded using a digital recorder, lasted around 30 minutes, and were conducted in a place provided by BHU. Then, they were transcribed and submitted to the content analysis formulated by Laurence Bardin, divided into three phases: pre-analysis, exploration of the material, and treatment of the results[13,14].

The study was approved by the research ethics committee of the Faculty of Medicine of Olinda, according to Resolution 466/2012 of the National Health Council. All patients signed the informed consent form.

RESULTS

Patients were mostly female (n = 11), aged between 40 and 60 years (n = 7), white (n = 7), married (n = 9), with an income of up to one minimum wage (n = 5), and up to eight years of education. Regarding clinical characteristics and lifestyle, some patients presented diabetes mellitus (DM) (n = 3), Parkinson's disease (n = 1), dyslipidemia (n = 1), labyrinthitis (n = 1), consumed alcohol (n = 5), and none of the patients smoked or used illicit drugs.

Considering Axis 1 (i.e., the experience of being hypertensive), three sub-axis were identified: signs and symptoms that led to the diagnosis of SAH, the feeling of what it is like to have SAH, and changes in routine after the diagnosis of SAH. In Axis 2 (i.e., reception and health care), the three following sub-axis were identified: reception, access, and difficulties encountered, which refer to the health team and the health care network available to these users.

Axis 1: The experience of being hypertensive

According to the report of the patients, the following signs and symptoms led to the diagnosis of SAH:

"I was feeling many headaches in the back of the neck and eagerness to vomit." (U3)

"I went to see my son at the BHU, and he had high blood pressure." (U4)

"I had a headache, thirst for vomit, and pallor." (U5)

"I had many headaches and looked for the health unit." (U8)

"I had a headache and looked for urgency."(U11)

The feeling of what it is like to have SAH:

"Not a very good thing, no." (U3)

"I think it is genetic." (U5).

"I do not know how to explain." (U7)

"Being hypertensive is bad." (U8)

"Being hypertensive is a disease." (U10)

"To be hypertensive is to be attentive." (U11)

"Being hypertensive is not good." (U12)

Changes in routine after the diagnosis of SAH:

"I changed my role at work, and I try to take care of food." (U1)

"I have improved my symptoms, although I am still having a headache." (U2)

"My diet has become more regulated, with less salt and carbohydrates." (U3)

"I do not drink anymore, and I do not eat salty food anymore." (U5)

"A lot has changed." (U6)

"It has changed practically nothing, just the routine of the medication." (U8)

"I no longer have headaches." (U10)

"I became more careful." (U12)

Axis 2: Reception and health care

Regarding the access, reception, and health care provided by the multidisciplinary team, the patients mentioned:

"I cannot make an appointment with a nutritionist to prescript my diet." (U8)

"I received guidance to diet, lose weight, and go for walks." (U9).

"I use the medication according to the medical prescription." (U10)

"I received guidance to avoid salt and carbohydrate and do physical activity." (U11)

"I was referred to the cardiologist." (U12)

Regarding the difficulties encountered throughout the process, the patients reported:

"I do not have difficulties in taking the medications." (U1)

"I take walks sporadically." (U2)

"I do not participate in the groups on my health unit." (U3)

"The doctor gave me food I cannot afford." (U6)

"I did not receive any kind of nutritional guidance." (U12)

DISCUSSION

Considering the results, most patients with SAH interviewed were female, married, and self-declared white. The presence of other comorbidities was also identified, such as DM, Parkinson's disease, dyslipidemia, and labyrinthitis. Although black people have a greater predisposition to SAH, most patients in this study were white. Studies conducted in other Brazilian states highlight the predominance of care for women, as they perceive their health problems more than men and seek more health services[5,17,18,19].

The low level of education and income identified by the patients may hinder treatment adherence, as well as the perception of the care received by the FHS team and the understanding of morbidity and mortality of the disease. As the therapeutic complexity increases, the patient needs more complex cognitive skills to understand the treatment and its adherence[15,14,18].

Regarding the experience of being hypertensive (Axis 1), the patients clearly did not know for sure the meaning of the disease or its consequences and severity[15]. They believed that changes in routine after the diagnosis of SAH linked to healthy eating influenced the reduction of symptoms. In this context, In this context, previous studies observed a lack of knowledge about the disease and its treatments. The authors emphasized that the correct use of medication, adequate nutrition, and practice of physical activities could reduce symptoms[15,16].

The patients believed medication was enough to control SAH; however, only pharmacological treatment is not effective for controlling this disease. Strategies that include weight control, dietary re-education, reduction in alcohol consumption, smoking cessation, and physical activity contribute to the control and treatment of SAH, and reduce the risk of cardiovascular diseases[14,15,23].

A study conducted in the Northeast of Brazil presented similar results, showing that health education is fundamental for treatment adherence and lifestyle changes, as knowledge of the disease improves the behavior of patients with SAH[20]. Adherence to treatment can be defined as the behavior of patients throughout the treatment presented by the health team, aiming to prevent complications and improve quality of life[21].

The presence of family members or close people to compose a support network for patients with NCDs is essential because continuous care is needed for greater treatment effectiveness. Monitoring blood pressure levels, correcting the use of medications, providing adequate nutrition, and practicing physical activities are also needed[7].

Regarding reception and health care (Axis 2), continued care is needed for patients with SAH, involving the multidisciplinary health team as co-responsible for the people living in the territory covered by the BHU. From this perspective, reception is a light technology in health that helps the organization of care, emphasizing that healthcare professionals need to conduct it with resoluteness and accountability[14,16]. The environment in which patients are inserted is also important, as well as respecting the specificities of each patient and their need for service and demand[23]**.**

In the Unified Health System (UHS), reception permeates the approach to the user, which is a space of first listening with the identification of the needs of the patients, guiding and directing them to solve their problems[20]. This process is included in the objectives of the National Humanization Policy and can promote practices of healthcare professionals to meet the needs of users in PHC[22,23].

Thus, the care of patients with SAH in the daily life of the FHS covers a representative demand that requires proper reception and health care since SAH is a highly prevalent disease that reduces the quality of life[20]. The main purpose of monitoring patients with SAH is to control the disease and prevent secondary complications, requiring the participation of the health team, the patient, and their family[11,21].

The turnover of healthcare professionals is associated with insufficient quantity, and their qualifications to work in PHC hinder the work of the FHS[20,21]. Thus, changes are needed in the meaning of individual consultations and the incorporation of health promotion, prevention, recovery, and rehabilitation actions in UHS. Expanding access to information and creating participatory strategies for health promotion and disease prevention is essential for strengthening the link between users and healthcare professionals[12].

CONCLUSION

The study highlighted that the perception of the users about the experience of being hypertensive is linked to the lack of knowledge about the disease and its forms of treatment. The proper use of medication, adequate nutrition, and the practice of physical activities directly influence the reduction and control of SAH symptoms.

Given the above, strengthening the dialogue between healthcare professionals and users is crucial to improve their monitoring and reception. Patients must be informed about the risk factors, treatment, and possible complications related to SAH using actions to promote health and improve quality of life.

CONFLICTS OF INTEREST

Nothing to declare.

CONTRIBUTIONS OF THE AUTHORS

FSRB: Conceptualization, Data curation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, and Writing – review and editing. **MNBLCB:** Research and Resources.

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