



## USER'S ADHERENCE TO HYPERTENSIVE DRUG THERAPY

*ADESÃO DO USUÁRIO HIPERTENSO À TERAPÊUTICA MEDICAMENTOSA*

*ADHESIÓN DEL USUARIO HIPERTENSO A LA TERAPÉUTICA MEDICAMENTOSA*

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The low treatment adherence is one of the major factors for the lack of blood pressure control and risk for cardiovascular diseases. We aimed to analyze the hypertensive user's adherence to drug therapy. A descriptive study carried out with 400 hypertensive users, from May to August 2010, through interviews. Most interviewees were female (67.2%), aged over 60 (54.3%) and with brown skin (57.4%). 326 (81.5%) users were making regular use of medicine with a predominance of those with over 10 years of diagnosis (33.5%), those with up to 5 years of treatment (31.0%), and those who received the complete medication provided by SUS (39.2%). The knowledge on the types of antihypertensive drugs and the daily frequency of medication prevailed regardless the regularity of medication, the same happened regarding the lack of knowledge on side effects, to the discomforts caused and the complexity of drug therapy. We concluded that the treatment adherence prevailed in most users.

**Descriptors:** Hypertension; Medication Adherence; Therapeutics.

A baixa adesão ao tratamento constitui um dos principais fatores do descontrole da pressão arterial, e de risco para as doenças cardiovasculares. Objetivou-se analisar a adesão do usuário hipertenso ao tratamento medicamentoso. Estudo descritivo realizado com 400 hipertensos, durante os meses de maio a agosto de 2010, através de entrevista. A maioria dos entrevistados era mulher (67,2%), idade acima dos 60 anos (54,3%), e pardos (54,7%). Cerca de 326 (81,5%) faziam uso regular do medicamento com predomínio dos entrevistados com mais de dez anos de diagnóstico (33,5%), até 05 anos de tratamento (31,0%), e que recebiam a medicação completa do Sistema Único de Saúde (39,2%). O saber sobre os tipos de drogas anti-hipertensivas e o número de tomadas diárias predominou independentemente da regularidade da medicação, o mesmo fato aconteceu em relação ao desconhecimento dos efeitos colaterais, aos desconfortos causados, e à complexidade do esquema medicamentoso. A adesão ao tratamento prevalecia na maioria dos usuários.

**Descritores:** Hipertensão; Adesão à medicação; Terapêutica.

La baja adherencia al tratamiento es uno de los factores de descontrol de la presión arterial y del riesgo para enfermedades cardiovasculares. El objetivo fue analizar la adherencia del usuario hipertenso al tratamiento medicamentoso. Estudio descriptivo, con 400 hipertensos, de mayo a agosto/2010, mediante entrevista. La mayoría era mujer (67,2%), edad mayor de 60 años (54,3%) y pardas (54,7%). Alrededor de 326 (81,5%) estaban tomando el medicamento con predominio de los usuarios con más de diez años después de diagnóstico (33,5%), hasta cinco años de tratamiento (31,0%), y que recibieron medicación completa del Sistema Único de Salud (39,2%). El conocimiento acerca de los tipos de fármacos antihipertensivos y el número de dosis diarias prevaleció independientemente de la medicación regular, lo que realmente sucedió según la ausencia de efectos secundarios, a las molestias causadas, y complejidad del esquema medicamentoso. Parece ser que la adherencia al tratamiento prevaleció en la mayoría de los usuarios.

**Descritores:** Hipertensión; Cumplimiento de la Medicación; Terapêutica.

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## INTRODUCTION

Systemic arterial hypertension (SAH) is one of the most important risk factors for morbidity and mortality in today's world, affecting about 20% to 25% of the world population, being the most important cause of death among adults with cardiovascular disease<sup>(1)</sup>. In Brazil, SAH represents a serious Public Health problem due to its high prevalence, between 15% and 20% in the adult population, and over 50% among the elderly, and because it affects individuals in their full productive phase. When associated with risk factors such as smoking, diabetes and dyslipidemia, it constitutes an important risk factor for cardiovascular diseases, responsible for nearly 30% of deaths<sup>(2)</sup>.

Its treatment, done through hygiene-dietetic and/or drug methods, has as main objective to reduce the cardiovascular morbidity and mortality of hypertensive patients, increased due to high levels of tension and other aggravating factors. Although antihypertensive treatment is effective, the non-adherence of hypertensive patients to this treatment contributes significantly to uncontrolled SAH, happening in up to 40% of users for different reasons, representing a challenge for health professionals<sup>(3)</sup>. In Brazil, where there are more than 15 million of hypertensive people, less than 10% of them have effective control of hypertension. Added to this, lack of information on the topic, concept distortions, social and economic problems, lack of resources for therapy implementation among others<sup>(3)</sup>.

The non-adherence to SAH treatment is identified not only through suspension or irregularity in drug treatment, but also with the adoption of inappropriate lifestyle. The last one is defined as failure to follow hygiene-dietetic measures, such as healthy eating, regular exercises, maintaining healthy weight, alcohol

and tobacco abstinence, stress management and proper use of beverages containing caffeine<sup>(4)</sup>.

The drug treatment is indicated for moderate and severe hypertensive patients, and for those with risk factors for cardiovascular diseases and/or significant target organs injury. However, few hypertensive patients achieve the ideal blood pressure (BP) control with just one single therapeutic agent, thus the combined therapy is often necessary, especially among elderly and individuals with significant comorbidities<sup>(5)</sup>.

About 16% to 50% of new patients with SAH discontinue the antihypertensive medication during the first year of use and a substantial number of those who remain on the medication, do it improperly<sup>(6)</sup>. Therefore, the adherence to antihypertensive treatment is low, and it has been identified as one the major factors responsible for the lack of BP control, along with its known deleterious implications. The possible causes for this non-adherence, which often has been observed in outpatient follow-up of hypertensive patients, include the partial and irregular distribution of antihypertensive drugs by the Unified Health System (SUS); low purchasing power of users; poor or lack of knowledge on the treatment itself, such as: regularity, name, therapeutic and adverse effects, drugs storage and safekeeping etc., besides discomforts and complexity of the drug therapy.

Non-adherence to drug treatment is related not only to taking or not the medication, but how the hypertensive users "manage" their treatment: the behavior regarding dose, time, frequency and duration. Conceptually, the non-adherence must be assumed as a multi-dimensional construct.

Therefore, non-adherence constitutes a serious obstacle to the successful SAH treatment. Thus, the identification of determinant factors for the treatment

non-adherence of hypertensive patients is of vital importance in the application of therapeutic strategy and in obtaining satisfactory results. Furthermore, the identification of these factors and their better knowledge could enable the implementation of measures that allow its correction, promoting adherence and providing adequate control of blood pressure levels <sup>(5)</sup>.

The traditional definition of adherence refers to the situation where an individual's behavior corresponds to the guidance of health professionals, assessed by attending the consultations, taking the prescribed medications and changing their lifestyle <sup>(7)</sup>. Factors such as socio-demographic variables, patient's knowledge and beliefs on SAH, the lack of symptoms, the chronicity, the comprehension of the health and illness concept, and social and family support, influence the adherence of hypertensive patients in controlling their aggravation <sup>(8)</sup>.

The U.S. National Institutes of Health conducted a research on the likely factors that hindered the effective antihypertensive treatment, and the most frequent barriers that led to treatment failure were: difficulty in changing the lifestyle (e.g., weight loss), failure in taking the medication as prescribed, lack of understanding of the health problem, medication costs, waiting time in consultation, improper consultation time and side effects <sup>(7)</sup>.

In a cross-sectional study the reasons that led patients to discontinuation of hypertension treatment were examined, 401 patients were interviewed at different centers in the state of Bahia and the biggest reasons observed that led to non-adherence were: normalization of blood pressure, drugs side effects, forgetting to take medications, cost of medications, fear of mixing medication and alcohol, lack of knowledge on the need for continuity of care, use of alternative treatments, fear of intoxication, fear of hypotension and fear of mixing the antihypertensive medication with

other drugs <sup>(9)</sup>.

The drug treatment of SAH is very effective in reducing blood pressure levels, however, the percentage of patients who achieve the therapeutic goals are low. Treatment non-adherence is one of the most important issues faced worldwide, because it causes substantial costs due to the low rates achieved, which ends up increasing the morbidity and mortality rates caused by this syndrome <sup>(10)</sup>.

Treatment non-adherence has been a major challenge for professionals that follow-up the clients, and possibly it has been responsible for the increased social costs, such as absenteeism at work, sick leave and disability retirement <sup>(11)</sup>.

In developing countries there is a huge waste of resources for medicines, reaching up to 40% of health budget, while in developed countries this amount is 8%. The level of patient compliance should be always examined, as well as the prescriptive behavior of health professionals, as part of quality of care assessment <sup>(12)</sup>.

The magnitude and impact of poor adherence in developing countries is also a consequence of both scarcity and unequal access to health services, as in China, Gambia and Seychelles, where the rates of medication adherence are only 43%, 27% and 26% respectively <sup>(12)</sup>. The effects of this non-adherence can be assessed by the number of death by strokes, which have been increasing in recent years in these countries <sup>(13)</sup>.

Considering the issues involved in this matter, as well as the importance of SAH control, we believe to be very relevant to understand the adherence in the context of antihypertensive treatment, once it will allow a more comprehensive understanding of the phenomenon, providing the basis for more effective interventions aiming to help hypertensive users to control or prevent damages caused by uncontrolled SAH <sup>(8)</sup>.

Given this reality of treatment non-adherence of hypertensive patients, the following question arises: what are the attitudes of these users specifically regarding the use of medication? Therefore the objective of this research was to analyze the adherence of hypertensive users to drug therapy.

The study findings will contribute to better understand the factors that interfere with the adherence to hypertension drug treatment, once it may provide a critical reflection on the part of professionals and managers, helping them to develop actions of health promotion that are often neglected.

## METHODS

This is a descriptive study that was carried out in a Family Health Center (CSF) of the 4<sup>th</sup> Regional Executive Office (SER IV), in Fortaleza-CE, Brazil.

The study population consisted of 1,600 hypertensive patients registered in Family Health Basic Units (UBASF), regardless of color, education, family income and marital status. The sample was calculated based on the prevalence of SAH, which was of 25% in the study area, with the formula for cross-sectional studies in a total of 400 users. As inclusion criteria in the study we used: UBASF users registered in Hiperdia, with prior diagnosis of SAH and in outpatient follow-up in the health service, excluding those who did not presented physical or emotional conditions to participate in the study. The Hiperdia is a computerized system that allows you to register and monitor patients with SAH and/or diabetes mellitus admitted and linked to healthcare units generating information for professionals and managers of local and state health departments and the ministry of health <sup>(1)</sup>.

Data collection happened from May to August 2010, through interviews with users, using a previously

validated structured questionnaire that contained questions regarding socio-demographic data and the adherence to drug treatment of SAH. We chose the interview due to the difficulty of the subjects in answering the self-explanatory questionnaire. We organized quantitative data in the software Statistical Package for Social Sciences (SPSS, version 18.0), representing them in chart and tables. We used pieces of participants' speeches, which were identified by order of interviews to preserve anonymity. Data were based on the pertinent literature on the study topic.

This research was carried out in accordance with the Resolution 196/96 of the National Committee for Research Ethics - CONEP <sup>(14)</sup>, which regulates researches involving human beings. We assured the participants the anonymity, the use of data obtained only for this study and the right to withdraw the consent whenever they wished. Data collection happened only after signing the Informed Consent Form and after the favorable opinion of the Ethics Committee of the Messejana Hospital/Ceará State Department of Health (SESA)/Unified Health System (SUS)/Ministry of Health, under protocol No. 194/04.

## RESULTS

According to Table 1, the majority of interviewees were female (67.2%), aged over 60 (54.3%), and had brown skin (54.7%). It is also worth mentioning that among them we identified 54 (13.5%) black people, 255 (63.7%) were literate or had attended only basic education and 79 (19.7%) were illiterate, 199 (49.7%) reported a monthly income of one to two minimum wages, and 194 (48.5%) had it from the retirement income of the National Social Security Institute (INSS). Thus, we verify that the monthly income was related to their education level.

**Table 1** - Distribution of hypertensive users according to age, gender, color, income, education and occupation. Fortaleza-CE, Brazil, 2010, n=400.

<b>Socio-demographic characteristics</b>	<b>N</b>	<b>%</b>
Age (years)		
20-39	10	2.5
40-59	173	43.2
≥60	217	54.3
Gender		
Male	131	32.8
Female	269	67.2
Color		
Brown	219	54.7
White	127	31.7
Black	54	13.5
Income <sup>1</sup>		
<1	142	35.5
1-2	199	49.7
≥3	59	14.8
Education		
Illiterate	79	19.7
Literate	148	37.0
Basic education	107	26.7
High school	54	13.0
Higher education	12	3.0
Occupation		
Retired	194	48.5
Housewife	99	24.7
Others <sup>2</sup>	107	26.8

<sup>1</sup> In standard minimum wages (R\$ 510.00). <sup>2</sup> Salesman, Driver, Housekeeper, Seamstress, Bricklayer, Farmer, Student.

In table 2 we verify that 290 (72.5%) interviewees were born in the interior of Ceará State, and 289 (72.2%) came from this state capital. It is also worth mentioning that 111 (27.7%) users lived in other municipalities of Ceará, needing to move to the capital

to perform the follow-up care of their health problem. As for religion, 311 (77.7%) reported being Catholic. In the sample, 216 (54.0%) were married, 331 (82.8%) lived in their own property and 150 (37.5%) lived with their spouse and children.

**Table 2** - Distribution of hypertensive users according to place of birth, place of residence, religion, housing conditions, marital status, who they live with. Fortaleza-CE, Brazil, 2010, n=400.

<b>Socio-demographic characteristics</b>	<b>N</b>	<b>%</b>
Place of birth		
Capital	110	27.5
Interior	289	72.2
Place of residence		
Capital	289	72.2
Interior	110	27.5
Religion		
Catholic	311	77.7
Protestant	67	16.7
Not informed	22	5.5
Housing conditions		
Rented	45	11.2
Own	331	82.8
Others <sup>1</sup>	24	6.0
Marital status		
Married	216	54.0
Single	42	10.5
Separated	45	11.2
Widow	74	18.5
Stable union	23	5.7
Who they live with		
Children	67	16.7
Spouse	39	9.7
Spouse and children	150	37.5
Others <sup>2</sup>	144	36.0

<sup>1</sup> Nursing home, Workplace, House of relatives and acquaintances. <sup>2</sup> Parents, Daughter-in-law, Uncles, Grandparents and Nephews.

According to Table 3, 326 (81.5%) hypertensive users were making regular use of the medicine, with prevalence of those with over 10 years of diagnosis (33.5%), those with up to 5 years of treatment (31.0%), and those who had access to the prescribed medication provided by SUS (39.2%). Among the interviewees, 42.2% purchased the medications that were missing in the CSF and/or were not standardized

by SUS through their own and/or family resources, which has been made easier since the creation of the Popular Pharmacy Program. For 83 (20.7%) users, the missing medication was donated by the Health Department of the city of origin.

Pieces of the interviewees' speeches show that the adherence to drug treatment was associated with BP control, cure of SAH, fear of complications, fixed times

for drug use, full and continuous availability of medication, financial condition to purchase the medication given the total or partial lack in SUS, and ability to purchase it through the Popular Pharmacy Program. *...the medicine is very important for pressure control, so when it is missing in the health center, I find a way and buy it... and now with the popular pharmacy it became easier to buy it, because it is cheaper than in other pharmacies...* (E123). *...I always take it at the same time, so I don't forget, because I don't want to have those consequences of high blood pressure - thrombosis, heart attack, stroke...* (E345).

Among the 74 (18.5%) users who were not taking medication regularly, in most cases (19.6%) SAH was

diagnosed between 6 to 10 years; the treatment was indicated more than 10 years ago; the drug therapy was fully accessible for 7.7% and partially for other 7.7%; and 9.7% purchased the medication.

Non-adherence was related to lack of financial resources to purchase the medication due to their lack in SUS, lifestyle unsuitability to the drug therapy, and chronicity of SAH. *...when the medication is missing in the health center, I stop taking it, because I have no money to buy it...* (E87). *...sometimes I don't take it when I have to go out, I'm too busy ... I sleep and I miss the time of taking it...* (E45).

**Table 3** - Distribution of hypertensive users according to regular use of medication and treatment data. Fortaleza-CE, Brazil, 2010, n=400.

Drug treatment	Regular use of Medication				Total	
	Yes		No		f	%
	f	%	f	%		
Time of SAH diagnosis (years)						
≤5	110	27.5	26	6.5	136	27.5
6-10	82	20.5	20	19.6	102	25.5
≥11	134	33.5	28	17.2	162	40.5
Time of treatment (years)						
≤5	124	31.0	26	6.4	150	37.5
6-10	86	21.7	20	4.9	106	26.5
≥11	116	29.0	28	7.0	144	36.0
Medication provided by SUS						
Total	157	39.2	31	7.7	110	27.5
Partial distribution	120	30.2	31	7.7	82	20.5
Total distribution	49	12.2	12	3.0	134	33.5
Purchase the medication						
Yes	169	42.2	39	9.7	208	27.5
No	83	20.7	19	4.7	102	25.5
Sometimes	74	18.7	16	4.0	90	22.5

In Table 4, among hypertensive users who were regularly taking antihypertensive medication, 304 (76.0%) informed the name of the drugs in use, 168 (42.0%) knew the daily frequency of medication, and only 10 (0.2%) knew the daily concentration of prescribed drugs.

The drug therapy of most hypertensive users

(61.3%) consisted of two to three antihypertensive drugs prescribed. For 161 (40.2%) users this was considered complex because it hindered the regular use due to the daily quantity, different times and daily time dedication for the medication. *...there are many medicines to take ...it is stressful because there are also several different times, and many times I have taken them wrong...* (E34). *...we have medicine for lunch and dinner, it is quite bad ...and if it wasn't for my daughter to*

give me the medicine properly, I don't know what would become of me... (E97).

Thirty-seven (9.2%) users knew the side effects of some drugs they used, for instance: increased diuresis volume and frequency when using diuretic drugs; facial flushing and swollen feet when using calcium channel inhibitors (Nifedipine); and in the case of sexual impotence, they were not able to associate with the type of drug. ...the C... gives a lot of coughing, so the doctor changed to another medication... (E341). ...the H... greatly increases the urine, but the doctor said it was like this... (E123). ...when I started taking the N... my face turned red and my feet swelled... (E213).

Seventy-seven (19.2%) interviewees complained of discomforts caused by antihypertensive drugs, such as: persistent cough, frequent diuresis, drowsiness, bitter taste, insomnia, dry mouth, adynamia, leg pain, nausea, epigastric pain, anorexia and sexual dysfunction. Some of these discomforts were associated with medication side effects, some from prolonged use and others with unknown origin. ...we take these medicines because we have to ...it gives us abdominal pain, dry mouth, increased urine, so much that we can't even leave the house... (E118). ...after I started the pressure treatment with these medicines, I no longer feel the taste of food... (E45).

**Table 4** - Distribution of hypertensive users according to regular use of medicine and knowledge on the drug treatment. Fortaleza-CE, Brazil, 2010, n=400.

Knowledge on the drug treatment	Regular use of Medication							
	Yes				No			
	Yes		No		Yes		No	
Drug treatment	f	%	f	%	f	%	f	%
Name of drugs	304	76.0	22	5.5	14	3.5	60	15.0
Daily frequency	168	42.0	158	39.5	41	10.2	33	8.2
Complexity	161	40.2	165	41.2	18	45.0	56	14.0
Discomforts	77	19.2	249	62.2	19	4.7	55	13.7
Side effects	37	9.2	289	72.2	09	2.2	65	16.2
Daily concentration	10	0.2	316	79.0	18	4.5	56	14.5

Time of treatment: up to 5 years,  $p > 0.05$  (there was association); 6 to 10 years,  $p < 0.05$  (there was no association); more than 10 years,  $p > 0.05$  (there was association).

We verified that the knowledge about the types of antihypertensive drugs and the daily frequency of medication prevailed regardless of the regularity of

medication, and the same fact happens with the lack of knowledge on side effects, to the discomforts caused and the complexity of the drug regimen.

## DISCUSSION

Women have a higher prevalence of SAH than men. They usually have a higher perception of illness, are more likely than men to self-care and to seek healthcare, which would increase the probability of having SAH diagnosed<sup>(15)</sup>.

Blood pressure increases linearly with age. In young individuals SAH arises most often only from high

diastolic blood pressure, whereas in people over 60 years the main component is the elevation of systolic blood pressure. Global estimates suggest higher rates of SAH among men up to 50 years and among women over 60 years<sup>(16)</sup>. This fact was verified in this study, in which the age range of interviewees was above 60 years old.

The clinical outcome is slow, it has multiple

factors and when not treated properly has serious complications, either temporary or permanent. It represents a high financial cost to society, mainly for its occurrence associated with aggravations such as cerebrovascular disease, coronary artery disease, chronic heart failure, chronic renal failure and peripheral vascular disease. Its chronic and silent characteristic complicates the perception of individuals with this problem. Therefore, it becomes "perverse" for its invisibility, and ends up compromising the quality of life. It also brings as consequences hospitalizations and technical procedures of high complexity, leading to absenteeism at work, early retirements and deaths, compromising the quality of life of the most vulnerable social groups<sup>(17)</sup>. People with the lowest education level have higher prevalence of SAH<sup>(15)</sup>.

Non-adherence to antihypertensive treatment consists in an event caused by many factors that are related to the users (age, gender, marital status, race, education, income, etc.), to the institution (health policies, difficulty access to health services, waiting time for consultation, drugs distribution, among others), and to the relationship with the health care team, i.e. inadequate involvement and relationship. However, in countries like Brazil it is a major problem and should be the first factor considered: if the patients have access to medication, so they are able to comply with the treatment<sup>(18)</sup>.

There is evidence that a treatment with two daily doses has an easier adherence than the ones with three doses. Moreover, it is also important to mention that the perception of side effects caused by treatment is a barrier to adherence, which can be called protective effect of non-adherence. We observed that these factors, usually identified to the medicines, are actually related to the patient's decision to change their lifestyle or accept certain adverse effects<sup>(19)</sup>.

The literature reports that the type of illness treated is related to adherence or not to treatment, which can be understood as how the patients see their condition and understand their illness<sup>(18)</sup>.

We should also consider that the cost of purchasing the medication when it is not provided by the SUS, just like the side effects, strongly influences on the adherence to the treatment proposed. The continuity of care is a fundamental part of antihypertensive treatment, reducing cardiovascular complications resulting from SAH, therefore such issues should be taken into account when planning the management of health resources, either public or private, since often approaches considered cost-elective can actually cost more in the future, not only financially but also in number of lives<sup>(20)</sup>.

Among the various factors mentioned in the literature, the first we can think of is the lack of access to medicine. The pharmaceutical market is concentrated in the richest countries and aimed at wealthy social classes. It is known that the largest investments are in developing treatment for problems that affect this population, in detriment of drugs demanded by the most common needs in the poorest countries<sup>(21)</sup>. Despite the cost of medicine represents a large part of investments in public health, in countries like Brazil the free distribution of medicines does not cover the current needs, despite major advances in this area<sup>(18)</sup>.

Data reveal that the knowledge on SAH, the fact of not considering the drug therapy complex and not feeling uncomfortable with the medication used constituted factors that increased adherence to drug treatment. It is worth mentioning that the unavailability of medication can seriously affect the users' adherence.

Thus, the non-adherence to SAH treatment may be caused by the undesired side effects of antihypertensive drugs, financial barriers, patient's lack

of motivation in treating an asymptomatic disease, treatment for life, inappropriate relationship with the healthcare team, among other factors.

The assistance for people with SAH requires special attention from the healthcare team regarding the control issue, which is closely related to the process of treatment adherence. And especially doctors, nurses, nursing technicians and assistants must be properly oriented on the specificities of this disease and treatment, in order to achieve better disease control<sup>(19)</sup>.

The importance of health professionals to hypertensive patients is related to their role as educators, aiming to motivate the patients regarding treatment adherence and self-care, proposing strategies that encourage their involvement in the SAH treatment. The nursing staff plays an important role in contributing to the disease prevention, its early diagnosis through routine measurement of blood pressure and increased levels of adherence to established health practices for hypertension. Once the disease is installed, the performance focuses on guiding the patients on the benefits of drug and non-drug treatment, management of the disease and its complications when not controlled, as well as adopting healthy lifestyles<sup>(20)</sup>.

The health professional inserted in the dynamics of social relationships can act expanding the critical consciousness of social groups regarding their potential of strengthening/exhaustion that they are exposed to in the way they work and live. Therefore, it is crucial that their practice is related to and guided on an educational proposal of social transformation<sup>(21)</sup>.

It is also important to point out that health users are not just consumers (of guidelines and educational groups, for example), they are also actors/co-producers of an educational process. They have two dimensions in the process: they are subjects of attention of educational agents and subjects of their own education.

The development of a care adherent to the needs of social groups incorporates this emancipatory educational dimension<sup>(22)</sup>.

Preventing risk factors and controlling SAH involves considering health education as a care strategy. In the process of health education, the care assumptions are based on considering that listening and welcoming must be valued, in order to lead the individual to comply with preventive and control measures of health problems<sup>(23)</sup>.

## CONCLUSION

Therefore, we concluded that the adherence to drug treatment prevailed among most users. We also identified several factors associated with this event, some having greater influence on users' adherence to SAH drug therapy.

Although hypertensive users have reported positive attitudes regarding the drug treatment, besides a reasonable knowledge on SAH and treatment, there is still the need to incorporate actions aimed at better control of blood pressure, especially when the drugs are not properly distributed, contributing to treatment non-adherence.

It is extremely important that such factors are raised and more deeply studied in order to clarify the connections with the treatment adherence. From this perspective, we expand the vision of a health professional who deals with these clients in order to improve their level of therapy adherence, which will contribute significantly to reduce the morbidity and mortality from cardiovascular events, resulting from the lack of control of blood pressure levels.

The study was limited by the fact it was carried out in only one Family Health Center, thus we propose that more researches are conducted in order to know the reality of other health facilities and contribute to

scientific knowledge of professionals who work directly

and indirectly with this population.

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Received: Aug. 8<sup>th</sup> 2011  
Accepted: May. 29<sup>th</sup> 2012