



Intervention of the family health team on treatment adherence by hypertension patients

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ABSTRACT. Current descriptive study with a quantitative approach comprises an analysis of Family Health Teams' activities on hypertensive users' treatment adherence, involving 70 professionals from a Family Health Team in Fortaleza CE Brazil. Data were collected through a questionnaire. Educational activities developed for hypertensive users' treatment adherence took the form of individual and group orientations during home visits, clinical visits, lectures, group meetings and conversation groups. The professionals' experience with regard to hypertensive persons' adherence ranged between good, through fair and difficult, and was related to aspects inherent to users, families, professionals and managers. Educative actions and distribution of drugs were important and necessary. Results show that adherence is a big challenge for health professionals, and that the team's intervention should be reconsidered according to the principles of the Brazilian Unified Health System (SUS) and on adherence determining factors.

Keywords: hypertension, patient compliance, health education, family health program.

Atuação da equipe saúde da família na adesão do usuário hipertenso ao tratamento

RESUMO. Trata-se de um estudo descritivo com abordagem quantitativa, que analisou a atuação da Equipe Saúde da Família na adesão do usuário hipertenso ao tratamento, desenvolvido com 70 profissionais da Equipe Saúde da Família, em Fortaleza/CE. Os dados foram coletados por meio de questionário. Constatou-se que as ações educativas desenvolvidas para a adesão do usuário hipertenso ao tratamento tinham a forma de orientações individuais e coletivas, que aconteciam através de visitas domiciliares, consultas, palestras, reuniões de grupo e rodas de conversa. A experiência dos profissionais na adesão da pessoa hipertensa variou entre boa, razoável ou difícil, e estava relacionada aos aspectos inerentes ao usuário, família, profissionais e gestores. As ações educativas e a distribuição de medicamentos eram consideradas importantes e necessárias. Conclui-se que a adesão ainda é um grande desafio para os profissionais da saúde, e que a atuação da equipe deverá ser repensada com base nos princípios do SUS e nos fatores determinantes da adesão.

Palavras-chave: hipertensão, cooperação do paciente, educação em saúde, programa saúde da família.

Introduction

Systemic Arterial Hypertension (SAH) is one of the most important issues in public health in Brazil due to the disease's predominance and late detection. In fact, hypertension is a multifactor and multi-cause disease with specific chronic characteristics, with highlights on its endurance, multiplicity of associated factors, long asymptomatic course, and slow, prolonged and permanent clinical evolution, coupled to the possibility for further complications (SANTOS, 2004; NOBRE et al., 2001).

One of the most common difficulties in the attendance to hypertensive people is their lack of adherence or commitment to treatment, especially difficult in the treatment of chronic conditions. In

fact, the number of studies on SAH treatment adherence is higher than that on other diseases most of which have the non-adherence type response.

Adherence to hypertension treatment is understood as the degree of coincidence between the behavior of the user and the recommendation of the healthcare professional in view of the treatment regimen. It is expected that this will result in the control of arterial pressure, the reduction in the incidence or delay in the occurrence of complications and an improvement in the quality of life. Although various strategies exist to evaluate the adherence to hypertension treatment, there is no consensus on a gold standard (SANTA-HELENA, et al., 2008). The methods can be direct, such as the dosage of the principle active/metabolite of the drug

or indirect, such as counting the tablets and user reports (GUSMÃO et al., 2009). Some authors have developed generic questionnaires to measure treatment adherence in chronic diseases, which can also be used for people with hypertension (BORGES et al., 2012).

Peres et al. (2003) found that 50% of hypertensive patients did not practice any therapy follow-up and only few that adhere have their arterial pressure under control. Further, 30 to 50% of hypertension patients interrupt their treatment during the first year, whilst 75% do so after five years. Primary care health activities for SAH become highly strategic in the wake of the epidemiological scenario showing such low adherence.

Within the Family Health Strategy (FHS), multiprofessional and interdisciplinary activities in a restricted area favor preventive and assistance actions on SAH. The development of actions that combine hypertensive patients, families and the community may favor commitment to prevention and/or therapeutic behavior so that morbimortality rates of SAH-associated diseases could be reduced.

It should be emphasized that the Family Health Strategy (FHS) aims to develop not only several health programs but especially those inherent to the detection and/or control of chronic diseases, among which SAH may be underscored. Case diagnosis, enrolment of affected persons, active search, treatment and educational actions are some of the strategies that should be developed in basic health care.

In spite of the guidelines towards family health care, a lack of bonding between SAH patients and health units may be perceived throughout Brazil (SOUSA et al., 2006). As a rule, attendance occurs in a non systematic manner or in emergency units.

The relevance of the commitment to treatment by the hypertensive patient triggers numberless concerns to identify factors that favor the patient's non adherence to treatment so that the family health team may be capable of taking decisions on the most appropriate solutions to the problem.

The following question is the core of current analysis: Has the family health team facilitated the commitment of the hypertensive patient to treatment?

Acknowledging the importance of team work by the health team and the need to know the influence of activities by the family health team on the control of hypertension, current analysis investigates the activities of Family Health Teams for the commitment of hypertension patients to treatment.

Results from current analysis will possibly optimize the activities of the Family Health Teams and promote the commitment to treatment by the hypertensive patient. It will benefit health institutions and improve treatment at such an intervention level. Consequently, vacancies in institutions will be available and complications caused by inadequate SAH control will be reduced.

Material and methods

Current descriptive analysis with a quantitative approach was developed at the Family Health Centers monitored by the Regional Executive Secretary VI in Fortaleza, Ceará State, Brazil. The latter comprises four Family Health Centers, each of which with five Family Health Teams.

Target population comprised all professionals forming the Family Health Teams, with 70 professionals: 29 community health agents; 17 nurse assistants; 16 nurses; 8 physicians.

Data were collected during two months by questionnaire with the following information: social and demographic traits; identification of activities inherent to attributions of Family Health Teams for the commitment to treatment by the hypertensive patient. Analysis was supplemented by qualitative information.

Data were organized in Statistical Package for Social Science 13 and given in tables and figures, analyzed according to contents analysis technique, based on the presuppositions of health education (BARDIN, 2004). For the processing of analysis, data were distributed in activities that favor the commitment to treatment by the hypertensive patient; experience with regard to the commitment to treatment by the hypertensive patient; determinant factors in the commitment to treatment by the hypertensive patient.

Research was developed according to Resolution 196/96 of the Brazilian Commission in Research Ethics (CONEP) (BRASIL, 1996). Anonymity and the right to quit research at any moment were assured to the participants. Data were collected after the favorable opinion (number 06-174) of the Ethics Committee of the University of Fortaleza (UNIFOR) was provided. Anonymity was guaranteed by identifying the participants by the initial letters of each professional category, namely, community health agent (CHA); assistant nurse (AN); nurse (N); physician (P), followed by the number corresponding to the order of data collection.

Results and discussion

Approximately 49 (70.0%) professionals were within the 20 - 39 years age bracket; 57 (81.4%)

were females; 33 (47.2%) were married; 33 (47.2%) were born in Fortaleza, Ceará State, Brazil; and 58 (82.9%) resided in the capital city. Fifty-two (81.4%) professionals informed that they exercised their profession between 1 and 10 years; 68 (97.1%) professionals informed that they worked within the Family Health Team, whereas approximately 67 (95.7%) were authorized to work in the Family Health Team and 55 (78.6%) in the follow-up of hypertensive patients.

Activities that favor the commitment to treatment by the hypertensive patient

Table 1 shows the activities of each Professional of the Family Health Team favoring commitment of the hypertensive patient to treatment.

Table 1. Distribution of FHT professionals according to their activities with the hypertensive patients' commitment to treatment. Fortaleza, Ceará State, Brazil, 2007. n = 70.

FHT Activity	CHA		AN		N		P		Total	
	f	%	f	%	f	%	f	%	f	%
Educational activities										
Individual guidance	25	86.2	12	70.5	14	87.5	4	50.0	55	72.4
Collective guidance	9	36.0	6	35.2	5	31.2	1	12.5	21	27.6
Strategies										
Home visits	20	80.0	6	35.2	8	50.0	2	25.0	36	58.0
Talks	5	17.2	2	11.7	4	25.0	1	12.5	12	19.4
Group meeting	4	13.7	3	17.6	-	-	-	-	7	11.4
Clinic visits	-	-	-	-	3	18.7	2	25.0	5	8.0
Chats	-	-	1	5.8	1	6.2	-	-	2	3.2

CHA - Health Community Agent (n = 29); NA - Assistant Nurse (n = 17); N - Nurse (n = 16); P - Physician (n = 8).

Table 1 demonstrates that Family Health Teams' activities with hypertensive patients comprise individual and collective educational actions through such strategies as clinic visits, talks, team meetings and chats. Individual guidance was given during home visits, clinic and nursing visits. Collective guidance was given at talks, group meetings and chats.

Individual educational activities were predominant in FHT, underscoring N (87.5%), HCA (86.2%) and AN (70.5%). Further, 36 (58.0%) professionals preferred the home visiting strategy, especially HCA (80.0%), followed by N (50.0%). Talks were provided by members of the FHT, often by N (25.0%). Group meetings were organized by CHA and AN, including the latter (17.6%). Clinic visits were chiefly provided by P (25.0%) and chats were developed exclusively by N (6.2%) and AN (5.8%).

The treatment of chronic disease patients tends towards an adaptation to this condition providing them with tools so that they would develop mechanisms, through their own resources, that would make them aware of the health/disease process. Consequently, they would identify, avoid and prevent complications and above all early death. Commitment to treatment is a

highly significant item included in the treatment. It is actually relevant for the success of health care and a challenge for both professionals and patients due to the complex variables implied (SILVEIRA; RIBEIRO, 2005).

The home visit strategy is often employed for individual guidance. It is actually a practice proper to the philosophy of the FHT, especially for the community agent, and the most quoted item in current study (BRASIL, 2001). Through home visiting professionals are made aware of the families' needs and develop educational activities characterized by personal guidance and home assistance. It is a rationalizing strategy that decreases the demands for hospital attendance or the permanence of hospitalized patients (REHEM; TRAD, 2005).

Health education is something that goes beyond cure assistance and comprises giving priority to preventive and promotional interventions. The development of educational practices in FHT, in conventional spaces such as education groups, or in informal spaces such as the physician's clinical visit at the patients' home during home visiting, materializes the assimilation of the integration principle by family health teams (ALVES, 2005).

Through an interdisciplinary attitude, the health team helps hypertensive patients, their families and community to achieve a higher health level by strategies foregrounded on dialogue and effective interaction. The health team is made up of several health professionals who, with their specific types of knowledge, integrate all, while maintaining the specificities during their attendance to the patients' needs (SANTOS; BARROSO, 2003).

Experiences with regard to hypertensive patients' commitment to treatment

Table 2 shows the experience of each professional from the FHT with regard to commitment to treatment by hypertensive patients. FHT classifies the experience as Good, Fair and Difficult.

Table 2. Distribution of professionals according to the type of experience in the hypertensive patients' commitment to treatment. Fortaleza, Ceará State, Brazil, 2007. n = 70.

Type of experience	CHA		AN		N		P		Total	
	f	%	f	%	f	%	f	%	f	%
Good	14	48.2	6	35.2	6	37.5	2	25.0	28	40.0
Fair	8	27.5	6	35.2	3	18.7	2	25.0	19	27.2
Difficult	7	24.1	5	29.4	7	43.7	4	50.0	23	32.8
Total	29	41.4	17	24.3	16	22.8	8	11.5	70	100.0

CHA - Health Community Agent (n = 29); NA - Assistant Nurse (n = 17); N - Nurse (n = 16); P - Physician (n = 8).

Table 2 shows that 28 (40%) health professionals consider good their experience on hypertensive

patients' commitment to treatment due to certain conditioning factors such as acceptance of professional behavior by patients, family involvement in the treatment, patients' motivation for commitment and the establishment of effective bonding between professionals and patients.

[...] when they commit themselves to guidance, the hypertensive patients are largely successful, especially when they accept our participation (HCA2).

[...] when the family is also committed to treatment, adhesion is easier [...] even when one is dealing with a low-wage population without any sanitary education (E7).

[...] some resistance exists; however, if the population is followed up, it will comply satisfactorily with the treatment [...] the bonding between the health professional and the patient is the main tool for the latter's commitment to treatment (P3).

According to the report by P3, resistance to treatment adhesion exists although bonding between the health professional and the patient makes the process somewhat easier. The importance of the family is underscored by N7. Besides the establishment of commitment and co-responsibility among health professionals and the population, bonding with the FHT member is highly relevant.

Commitment to treatment is a multi-factor process structured between the care giver and the patient. It deals with frequency, constancy and perseverance with regard to health care. Therefore, bonding between the health professional and the patient is a structural factor and a consolidation of the process. It should be highly appreciated so that it could be put into effect (SILVEIRA; RIBEIRO, 2005).

In the opinion of 19 (27.2%) health professionals, the experience of commitment of the hypertensive patient was fair owing to professional learning derived from an exchange of knowledge with the hypertensive patient, regular use of anti-hypertensive drugs and frequency of clinic visits.

[...] some patients accept our work and this is good for our professional learning; Exchange of experiences is also extant (HCA1).

[...] some patients use drugs regularly but are reluctant to change their eating habits [...] (AN14) [...] hypertensive patients have frequent medical visits; they regularly take anti-hypertensive drugs. The difficulty lies in eating re-education (N13).

Following medical treatment is rather fair even though there are difficulties in many cases. This may be due to discomfiture caused by the drugs' side effects (M3).

The identification of variables involved in the non-commitment to therapeutic behavior is required of health professionals. The activity of several FHT professionals within an interdisciplinary stance is likewise mandatory so that hypertensive patients commit themselves to therapy.

It may be underscored that non-pharmacological attitudes are those less exercised when the compliance with therapeutic guidance for the control of arterial blood pressure is taken into account. Difficulties in commitment to SAH treatment exist because people fail to change their life style, namely, incorrect usage of specific drugs; diets without any salt or fat restrictions, overweight, non-practice or irregular practice of physical activities; failure to lessen smoking and drinking habits.

Few studies on adhesion indexes among hypertensive people are extant worldwide and in Brazil. Often studies cannot be compared either because of different profiles or because of different methods to identify adhesion. Due to its complexity, therapeutic commitment has recently become one of the most important issues in medical practice (BARBOSA; LIMA, 2006). Between 40 and 60% of patients fail to follow the medical prescription. The percentage increases when lack of commitment applies to life style, comprising proper diet, lack of physical activities, smoking, consumption of alcoholic beverages and others (BÉRIA, 2006).

In the opinion of 23 (32.8%) health professionals, the commitment experience was somewhat difficult and was related to forgetting to take drugs, quitting of treatment, lack of symptoms, resistance to proper eating habits, inadequate conditions of survival, inadequate dispensing of anti-hypertensive drugs, conviviality with stress situations and unemployment.

[...] most hypertensive patients forget to take their medicine, others quit treatment; hypertension is really a silent illness (HCA9).

[...] hypertensive people refuse to adopt healthy eating habits (AN17).

[...] very poor people, lacking minimum condition of survival, without any chance for having a balanced diet, lack of medicine in the health units, experiencing constant stress situations, unemployment and domestic violence (N1).

Although different drugs are on the market, the lack of these products is a frequent occurrence in primary health care of the Brazilian Health System (SUS), with the subsequent discontinuity in treatment and difficult SAH control at the lowest

social layers. The above contributes towards the quittance of therapy or non commitment to it (LESSA, 2006).

Determinant factors in the commitment to treatment by hypertensive patients

Table 3 shows suggestions favorable to treatment adhesion by hypertensive patients, according to each health professional.

Table 3. Distribution of health professionals according to suggestions favorable to the commitment to treatment by the hypertensive patient. Fortaleza, Ceará State, Brazil, 2007. n = 70.

FHT Suggestions	CHA		AN		N		P		Total	
	f	%	f	%	f	%	f	%	f	%
Educational activities	10	29.0	3	17.6	3	18.7	1	12.5	17	24.2
Systematic follow-up of patients	2	6.8	3	17.6	6	37.4	2	25.0	13	18.5
Maintenance of drug stocks	3	10.3	-	-	4	25.0	4	50.0	11	15.7
Acceptance of patient	3	10.3	3	17.6	3	18.7	-	-	9	12.8
Upgrading of FH team	3	10.3	1	5.8	5	31.2	-	-	9	12.8
Involvement of family in the treatment	2	6.8	1	5.8	3	18.7	2	25.0	8	11.4
Managing the required factors for educational activities	2	6.8	1	5.8	2	12.5	2	25.0	7	10.0
Proper physical infrastructure	-	-	3	17.6	4	25.0	-	-	7	10.0
Patient's awareness on illness and treatment	1	3.4	2	11.7	2	12.5	1	12.5	6	8.5
Application of the BHS principles	1	3.4	2	11.7	2	12.5	1	12.5	6	8.5
Fixation of physician in the FHT	2	6.8	2	11.7	-	-	-	-	4	5.7
Home visits	1	3.4	1	5.8	1	6.2	-	-	3	4.2

CHA - Health Community Agent (n = 29); NA - Assistant Nurse (n = 17); N - Nurse (n = 16); P - Physician (n = 8).

Table 3 underscores the educational activities (24.2%) among the suggestions provided by the FHS, even though the latter has pinpointed other types of behavior, such as the patients' systematic follow-up (18.5%), family involvement in the treatment (11.4%), management of factors required for educational activities (10.0%), patients' awareness on illness and treatment (8.5%) and the application of the BHS principles (8.5%). The above suggestions were not emitted by all the FHT members. The team reinforced that educational activities should be executed through campaigns, marches, talks and discussion groups.

Educational activities are highly relevant to improve the patients' health conditions. The patients adopt attitudes for the improvement of their health conditions according to provided information. The health professionals' testimony reveals a series of important activities that may be practiced on the health unit premises. However, it is well known that individual attendance prevails in the case of the

hypertensive patient when insistence on family involvement or group therapy fails to exist.

[...] promote walks with the group, prizes for those who manage to control their arterial pressure, since other hypertensive patients may become aware that they too could enjoy a healthy life (CHAS20).

A campaign on the radio and TV, calling people over 20 to verify their arterial pressure at health units, regardless of the illness of their forebears (CHA12).

[...] dynamics, more talks, commitment of health professionals and of hypertensive patients (NA15).

Health Units of Fortaleza, make available rooms for educational activities with series albums and videos (N10).

[...] group attendance coupled to walking (P8).

However, activities in health promotion do not merely consist in health education restricted to changes in behavior but also imply working the potentialities of each community and with real values that would make possible transformation and awareness, or rather, a new concept of citizenship. According to Lima et al. (2010), WHO insists that commitment degree to treatment is directly impacted by health care models. Consequently, the health attention model conceived by the Family Health Strategy would probably explain that in Brazil isolated studies on commitment to treatment show that SAH control remains at rates between 20 and 40% and quittance rates increase sometime after the start of therapy.

The evaluation and interpretation of the subjects' perceptions are activities that health professionals should face to direct their intervention and define more appropriate strategies to SAH patients.

Thirteen (18.5%) professionals suggested hypertensive patients' systematic follow-up regarding the regular use of drugs, guidance on the illness communicated to patients and family members, emphasis on the quality of attendance and evaluation of the patients' health conditions.

[...] make the patient accountable, telling him to take the correct drugs and to be punctual in their administration (CHA2).

[...] guarantee good attendance with any lack of drugs and excellent attendance, following up his evolution day by day (AN4).

The hypertensive patient should be given guidance on the disease's pathology and complication, together with his family (N7).

[...] constant follow-up by the health team (P1).

The activity of multiprofessional teams should be underscored. The variables involved and the factors associated with quittance of treatment or non compliance to therapeutic orientations should be identified while taking into consideration the available structure of the population's attendance. The strategy should start at the first encounter with the patient and frequently repeated to maintain its effects.

In the opinion of 11 (15.7%) and 7 (10.0%) health professionals, the maintenance of drug stocks and the management of the necessary tools for educational activities respectively contribute significantly towards the adhesion to treatment by the hypertensive patient

[...] all medicines should be given at the Family Health Centers, according to each patient (N4).

[...] managers should administer more tools to educational practices while medicine and human resources should never be lacking (N8).

[...] above all, medicine stock consistency which is the main cause of non controllability in my patients (P2).

[...] greater availability of medicines in the Family Health Centers so that they would never be lacking (P5).

In spite of the financial resources for the programs Basic Pharmaceutical Assistance and Popular Pharmacy, complaints on the lack of drugs in Family Health Centers are notorious. It is actually an important factor for future non adhesions since financial problems are constant in hypertensive patients attended by the FHCs.

Availability and costs in the selection of drugs should be undertaken since undoubtedly these factors affect commitment to treatment. A study on the evaluation of assistance to patients with diabetes and/or hypertension within the Family Health Program showed that only 27 out of the 64 interviewed patients said they received from the FHP all the medicine they needed. Thirty-one (83.8%), out of the 36 (57.8%) patients who complained they did not receive from the FHP all the medicine needed, said that they had to buy them; 4 (10.8%) went to other FHCs or to neighboring towns; 2 (5.4%) waited for the arrival of the drugs at the health units (PAIVA et al., 2006).

Nine interviewed (12.8%) health professionals believed that commitment to treatment would improve if the hypertensive patient received a more humane attendance.

[...] give more attention to the patient, with understanding and patience (CHA1).

A hearty welcome guarantees the continuity of treatment in attendance and medication shifts (N12).

[...] when we work with patients, we should always be prepared to listen and to understand the difficulties of each patient, with patience, so that together we would find a better form for treatment commitment and with a better life quality (N13).

Acceptance is a technical and assistance activity that presupposes changes in the health professional-patient relationship and their social network through technical, ethical, humanitarian and solidarity parameters. At the same time, it acknowledges patients as participating and active subjects within the process of health production (BRASIL, 2004).

Acceptance is a manner of working out health processes so that all those who seek health services would be well attended and their claims listened to. The health professional would be able to welcome, listen to and give adequate answers to patients. It also implies attendance with resoluteness and responsibility, providing guidance, if required, to patients and their families with regard to other health services and continuation of assistance while establishing links with these services to guarantee the efficiency of attendance (BRASIL, 2004).

The physical infrastructure of FHCs was recommended by 7 (10.0%) health professionals since they claimed that a well-equipped health unit should be attendance friendly.

[...] besides, provide a proper place for attendance (AN1).

[...] a proper place, with a good physical structure of a health unit, improving access to medical specializations (N9).

Commitment to anti-hypertensive treatment may be affected by several inter-related factors. Acknowledgement of commitment determination factors is highly relevant for its materialization among hypertensive patients. Factors include the patient (gender, age, ethnicity, marital status, schooling level and social and economical data); illnesses (chronic, without any symptoms); beliefs, cultural and life habits (awareness of the seriousness of the illness, unawareness, experience with disease, family context, concepts of health and illness, self-esteem); treatment (costs, undesired effects, complex schemes, life quality); institutional aspects (health policy, accessibility, distance, waiting and attendance time); relationship with health team (inadequate involvement and relationships) (PIERIN, 2005). Further, the participation of the family may be included. In fact, it directly and

indirectly makes possible commitment to treatment owing to the modifying influence of the other factors mentioned above. When family participation occurs in a positive way, the family care giver contributes towards the adhesion process since changes in the patients' health modify the entire family (SARAIVA et al., 2007).

Nine (12.8%) health professionals mentioned the need for a continuous upgrading of the Family Health Team, comprising studies on the most frequent pathologies in the health units, whereas 4 (5.7%) health professionals insisted that a resident physician in the FHC would contribute towards the adhesion of hypertensive patients to treatment.

[...] more upgrading for the FHT through talks (CHA26).

[...] provoke the FHS for a resident physician (N14).

[...] importance of a resident physician in the team so that flaws in visits would not occur (AN6).

[...] health units should provide upgrading courses and thus prevent problems for health professionals... (N15).

As a rule, the satisfaction of the hypertensive patient with attendance is worth underscoring. In fact, the way health professionals relate themselves to hypertensive patients and the team's adequate training are key-point for the patients' commitment.

The opinion of N14 is noteworthy since no professional may be a substitute for another and the availability of a multidisciplinary team for the attendance of hypertensive patients is highly relevant. Since SAH is a multi-cause and multi-factor illness, it requires many types of approach and only a multidisciplinary team provides differentiated actions.

In several municipalities high turnover in FHTs and replacements of physicians have been reported. This is frequently due to changes in political administrations. The above facts hinder the establishment of links with the community and, consequently, with health activities, since the activities of the entire team are fundamental for health promotion. The physician's role is to maintain constant vigilance on the appearance of side effects to anti-hypertensive drugs and employing criteria foregrounded on clinic epidemiology and on results of well-delineated clinical studies for the individualized selection of the best drug for each patient. The physician must encourage and educate the patient and provide him with information on the illness's clinical significance and prognostics (COELHO; NOBRE, 2006).

Considering the family as an ally within the commitment policy, eight (11.4%) health professionals mentioned its involvement in the treatment, coupled to guidance to the hypertensive patient and to the family on the illness's complications.

[...] involving the entire family so that it may also help the patient in the treatment (CHA 3).

The hypertensive patient should be oriented on the pathology and its complications; the family too should receive the same guidance. The family is actually the best ally of the FHS team due to a better commitment to treatment by the hypertensive patient when it is involved (N2).

[...] more activities with the family through health agents and care givers (P1).

In the opinion of many hypertensive patients, one of the most important aspects is family support. An example suffices: a member of the family reminds the patient when to take his drugs and guides him on diet. Further, another member may accompany the hypertensive patient during clinic visits since often, due to very old age or other limitations, the patient does not have the required conditions to go alone to the health unit or to the doctor's (SARAIVA et al., 2007).

The patients' and the family's awareness on the disease and its treatment through guidance were suggested by 6 (8.5%) health professionals with regard to self-care.

[...] through proper dialogue that would make aware the patient of the relevance of a healthier life style that would lead him to self-care. Orientations to and awareness of the family are also highly important (AN2).

The benefits of a good relationship between the health professional and the patient are underscored in the literature, resulting in dialogue and proper communication. The good relationships that the health team establishes with patients are relevant. In fact, the latter feel the need to communicate their anxieties, symptoms and limitations. They need support and encouragement to adapt themselves to the disease.

Team work coupled to the participation of the patients' family members is highly beneficent and provides better commitment to treatment. The group stimulates reflection, broadens the information level and permits the speak up of one's opinion. An exchange of experience ensues. The above technique functions as a social support as patients ally themselves around a common issue and are sustained by a supporting team (ARAÚJO; GARCIA, 2006).

The application of the Brazilian Health System was suggested by 6 (8.5%) health professionals for better commitment through integrity, accessibility and equality.

[...] improves life style, with an integral attendance, warranting accessibility and equity for all (N8).

Universality, equality and equity are the BHS's principles. Equity as a complementary element to equality means the treatment of differences for equality. Therefore, the system should attend to all according to their requirements, regardless of payment, and work integrally so that health activities target the individual and the community for promotion, prevention and treatment (MENDES, 2002).

The evaluation of health services should be incorporated within the planning and decision-making at the local level, including the participation of health professionals. A better health service provision will surely be obtained for the hypertensive patient. It includes control of blood pressure levels, decrease in the incidence or delay of complications and an improvement in the patients' life style.

Conclusion

Results evidence that commitment to treatment is a great challenge for health professionals. Foregrounded on the BHS's principles, on the precepts of the National Policy for Humanization and on the determining factors of adhesion, the Family Health Team should ponder on its activities to re-plan strategies that would diversify and broaden its activities. Re-thinking would expand the activities of primary health care and strengthen the BNS's principles to make available the commitment of hypertensive patients to therapeutic and preventive behaviors. The policy will promote the patients' health and that of their family and consequently lessen the SAH issue within the Public Health responsibility. This is especially true because the problem will certainly increase in the wake of predominant numbers of elderly people for 2020 in Brazil.

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References

- ALVES, V. S. Um modelo de educação em saúde para o Programa Saúde da Família: pela integralidade da atenção e reorientação do modelo assistencial. **Interface, Comunicação, Saúde, Educação**, v. 9, n. 16, p. 39-52, 2005.
- ARAÚJO, G. B. S.; GARCIA, T. R. Adesão ao tratamento anti-hipertensivo: uma análise conceitual. **Revista Eletrônica de Enfermagem**, v. 8, n. 2, p. 259-272, 2006.
- BARBOSA, R. G. B.; LIMA, N. K. C. Índices de adesão ao tratamento anti-hipertensivo no Brasil e no mundo. **Revista Brasileira de Hipertensão**, v. 13, n. 1, p. 35-38, 2006.
- BARDIN, L. **Análise de conteúdo**. Lisboa: Edições 70, 2004.
- BÉRIA, J. U. Prescrição de medicamentos. In: DUNCAN, B. B.; SCHMIDT, M. I.; GIUGLIANI, E. R. J. (Org.). **Medicina ambulatorial: condutas clínicas em atenção primária**. Porto Alegre: Artmed, 2006. p. 54-57.
- BORGES, J. W. P.; MOREIRA, T. M. M.; RODRIGUES, M. T. P.; OLIVEIRA, C. J. The use of validated questionnaires to measure adherence to arterial hypertension treatments: an integrative review. **Revista da Escola de Enfermagem da USP**, v. 46, n. 2, p. 487-494, 2012.
- BRASIL. Ministério da Saúde. Conselho Nacional de Saúde (Brasil). Resolução nº 196, de 10 de outubro de 1996. Aprova diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. **Diário Oficial da União**, Brasília, n. 201, p. 21082, 16 Out., 1996. Seção 1.
- BRASIL. Ministério da Saúde. Secretaria Executiva. **Programa Agentes Comunitários de Saúde - PACS**. Brasília: Ministério da Saúde, 2001.
- BRASIL. Ministério da Saúde. Secretaria Executiva. Núcleo Técnico da Política Nacional de Humanização. **Humaniza SUS: acolhimento com avaliação e classificação de risco: um paradigma ético-estético no fazer em saúde**. Brasília: Ministério da Saúde, 2004.
- COELHO, E. B.; NOBRE, F. Recomendações práticas para se evitar o abandono do tratamento anti-hipertensivo. **Revista Brasileira de Hipertensão**, v. 13, n. 1, p. 51-54, 2006.
- GUSMÃO, J. L.; GINANI, G. F.; SILVA, G. V.; ORTEGA, K. C.; MION JÚNIOR, D. Adesão ao tratamento em hipertensão arterial sistólica isolada. **Revista Brasileira de Hipertensão**, v. 16, n. 1, p. 38-43, 2009.
- LESSA, I. Impacto social da não adesão ao tratamento da hipertensão arterial. **Revista Brasileira de Hipertensão**, v. 13, n. 1, p. 39-46, 2006.
- LIMA, T. M.; MEINERS, M. M. M. A.; SOLER, O. Perfil de adesão ao tratamento de pacientes hipertensos atendidos na Unidade Municipal de Saúde de Fátima, em Belém, Pará, Amazônia, Brasil. **Revista Pan-Amazônica de Saúde**, v. 1, n. 2, p. 34-43, 2010.

- MENDES, E. V. **A atenção primária à saúde no SUS**. Fortaleza: Escola de Saúde Pública do Ceará, 2002.
- NOBRE, F.; PIERIN, A. M. G.; MION JÚNIOR, D. **Adesão ao tratamento** – o grande desafio da hipertensão. São Paulo: Lemos, 2001.
- PAIVA, D. C. P.; BERSURA, A. A. S.; ESCUDER, M. M. L. Avaliação da assistência ao paciente com diabetes e/ou hipertensão pelo programa de saúde da família do município de Francisco Morato, São Paulo. **Cadernos de Saúde Pública**, v. 22, n. 2, p. 377-385, 2006.
- PERES, D. S.; MAGNA, J. M.; VIANA, L. A. Portador de hipertensão arterial: atitudes, crenças, percepções, pensamentos e práticas. **Revista de Saúde Pública**, v. 37, n. 5, p. 635-642, 2003.
- PIERIN, A. M. G. Adesão ao tratamento – conceitos. In: NOBRE, F.; PIERIN, A. M. G.; MION JUNIOR, D. (Org.). **Adesão ao tratamento**: o grande desafio da hipertensão. São Paulo: Lemos, 2005. p. 21-34.
- REHEM, T. C. M. S. B.; TRAD, L. A. B. Assistência domiciliar em saúde: subsídios para um projeto de atenção básica brasileira. **Ciência e Saúde Coletiva**, v. 10, supl., p. 231-242, 2005.
- SANTA-HELENA, E. T.; NEMES, M. I. B.; ELUF-NETO, J. Desenvolvimento e validação de questionário multidimensional para medir não-adesão ao tratamento com medicamentos. **Revista de Saúde Pública**, v. 42, n. 4, p. 764-767, 2008.
- SANTOS, Z. M. S. A. Atendimento multiprofissional e interdisciplinar à clientela hipertensa. **Revista Brasileira de Promoção da Saúde**, v. 17, n. 2, p. 86-91, 2004.
- SANTOS, Z. M. S. A.; BARROSO, M. G. T. A interdisciplinaridade na fundamentação da promoção da saúde. In: BARROSO, M. G. T.; VIEIRA, N. F. C.; VARELA, Z. M. V. (Org.). **Educação em saúde no contexto da promoção humana**. Fortaleza: Demócrito Rocha, 2003. p. 55-60.
- SARAIVA, K. R. O.; SANTOS, Z. M. S. A.; LANDIM, F. L. P.; LIMA, H. P.; SENA, V. L. O processo de viver do familiar cuidador na adesão do usuário hipertenso ao tratamento. **Texto e Contexto - Enfermagem**, v. 16, n. 1, p. 63-70, 2007.
- SILVEIRA, L. M. C.; RIBEIRO, V. M. B. Grupo de adesão ao tratamento: espaço de ensinagem para profissionais de saúde e pacientes. **Interface Comunicação, Saúde Educação**, v. 9, n. 16, p. 91-104, 2005.
- SOUSA, L. B.; SOUZA, R. K. T.; SCOCHI, M. J. Hipertensão arterial e saúde da família: atenção aos portadores em município de pequeno porte na região sul do Brasil. **Arquivos Brasileiros de Cardiologia**, v. 87, n. 4, p. 496-503, 2006.

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