

ADHERENCE TO ANTIHYPERTENSIVE MEDICATION, PRESSORIC CONTROL AND ASSOCIATED FACTORS IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: to evaluate adherence to antihypertensive medication, blood pressure levels, and associated factors in hypertensive individuals monitored by primary health care.

Method: a cross-sectional, descriptive and analytical study, carried out in Family Health Strategies in the city of Recife, Brazil. Data collection took place from April to August 2018. To assess adherence, the Morisky Medication Adherence Scale was used, an 8-item scale that addresses some behaviors when taking antihypertensive medication, such as: forgetfulness, non-intentional intake, reduced dose, interruption of treatment, and discomfort following the prescription. In the data analysis, the Chi-square and *Kruskal-Wallis* tests were used.

Results: a total of 421 hypertensive individuals participated in the study. Low, medium and high adherence was observed, respectively, at 48.5%, 38.7% and 12.8%. High/Medium adherence was associated with single individuals ($p=0.005$), without work activity ($p=0.043$), who did not report stress ($p=0.001$) and hypertensive urgency/emergency ($p=0.037$), without side effects of antihypertensive drugs ($p=0.012$), and who made continuous use of other drugs ($p=0.001$). Blood pressure control was verified in 205 hypertensive individuals and an association was established with females ($p=0.033$), younger age ($p=0.041$), higher schooling ($p=0.008$), use of up to 2 antihypertensive drugs ($p=0.006$) and absence of side effects ($p=0.026$).

Conclusion: the predominance of low adherence and uncontrolled pressure in some groups show the need to redirect health promotion actions in primary care, especially in the program for people with arterial hypertension and diabetes mellitus.

DESCRIPTORS: Cooperation and adherence to the treatment. Medication adherence. Arterial hypertension. Primary health care. Nursing.

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ADESÃO À MEDICAÇÃO ANTI-HIPERTENSIVA, CONTROLE PRESSÓRICO E FATORES ASSOCIADOS NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: avaliar a adesão medicamentosa anti-hipertensiva, os níveis pressóricos e os fatores associados nos indivíduos hipertensos acompanhados pela atenção primária à saúde.

Método: estudo transversal, descritivo e analítico, realizado em Estratégias de Saúde da Família do município do Recife, Brasil. A coleta de dados ocorreu no período de abril a agosto de 2018. Para avaliação da adesão, utilizou-se o *Morisky Medication Adherence Scale*, uma escala de 8 itens que aborda alguns comportamentos diante da ingestão do medicamento anti-hipertensivo, tais como: esquecimento, não ingestão intencional, redução da dose, interrupção do tratamento e incômodo no seguimento da prescrição. Na análise dos dados, foram utilizados os testes Qui-quadrado e *Kruskal-Wallis*.

Resultados: participaram do estudo 421 indivíduos hipertensos. A baixa, média e alta adesão foram vistas, respectivamente, em 48,5%, 38,7% e 12,8%. A alta/média adesão associou-se aos indivíduos solteiros ($p=0,005$), sem atividade laboral ($p=0,043$), que não referiram estresse ($p=0,001$) e urgência/emergência hipertensiva ($p=0,037$), com ausência de efeitos colaterais das drogas anti-hipertensivas ($p=0,012$), e que faziam uso contínuo de outros medicamentos ($p=0,001$). O controle da pressão arterial foi verificado em 205 indivíduos hipertensos e estabeleceu associação com o sexo feminino ($p=0,033$), idade mais jovem ($p=0,041$), maior escolaridade ($p=0,008$), uso de até 2 drogas anti-hipertensivas ($p=0,006$) e ausência de efeitos colaterais ($p=0,026$).

Conclusão: o predomínio da baixa adesão e o descontrole pressórico em alguns grupos evidenciam a necessidade de redirecionamento das ações de promoção à saúde na atenção primária, especialmente no programa para portadores de hipertensão arterial e diabetes mellitus.

DESCRITORES: Cooperação e adesão ao tratamento. Adesão à medicação. Hipertensão arterial. Atenção primária à saúde. Enfermagem.

ADHESIÓN A LA MEDICACIÓN ANTI-HIPERTENSIVA, AL CONTROL DE LA PRESIÓN Y A FACTORES ASOCIADOS EN LA ATENCIÓN PRIMARIA DE LA SALUD

RESUMEN

Objetivo: evaluar la adhesión a la medicación anti-hipertensiva, los niveles de presión y los factores asociados en personas hipertensas monitoreadas por el servicio de atención primaria de la salud.

Método: estudio transversal, descriptivo e analítico, realizado en unidades de la Estrategia de Salud de la Familia del municipio de Recife, Brasil. La recolección de datos tuvo lugar en el período de abril a agosto de 2018. Para evaluar la adhesión se utilizó la *Morisky Medication Adherence Scale*, una escala de 8 ítems que aborda algunos comportamientos frente a la toma del medicamento anti-hipertensivo, como ser: olvido, no tomar el medicamento de manera intencional, reducción de la dosis, interrupción del tratamiento e incomodidad para respetar la prescripción. En el análisis de los datos, se utilizaron las pruebas chi-cuadrado y de *Kruskal-Wallis*.

Resultados: del estudio participaron 421 personas hipertensas. Se observaron los niveles bajo, medio y alto de adhesión en el 48,5%, 38,7% y 12,8%, respectivamente. El nivel alto/medio de adhesión se asoció a personas solteras ($p=0,005$), sin actividad laboral ($p=0,043$), que no reportaron padecer estrés ($p=0,001$) y urgencia/emergencia relacionada con la hipertensión ($p=0,037$), con ausencia de efectos secundarios causados por los medicamentos anti-hipertensivos ($p=0,012$), y que consumían otros medicamentos en forma continua ($p=0,001$). El control de la presión arterial se verificó en 205 individuos hipertensos y se estableció una asociación con el sexo femenino ($p=0,033$), menor edad ($p=0,041$), mayor nivel de estudios ($p=0,008$), uso de hasta 2 medicamentos anti-hipertensivos ($p=0,006$) e ausencia de efectos secundarios ($p=0,026$).

Conclusión: el predominio del bajo nivel de adhesión y el no control de la presión en algunos grupos ponen de manifiesto la necesidad de redireccionar las acciones de promoción de la salud en la atención primaria, especialmente en el programa para pacientes con hipertensión arterial y diabetes mellitus.

DESCRIPTORES: Cooperación y adhesión al tratamiento. Adhesión a la medicación. Hipertensión arterial. Atención primaria de la salud. Enfermería.

INTRODUCTION

Adherence to a health treatment is an indispensable aspect to be considered in the management of a clinical condition, as it impacts on the success of the prescribed therapy.¹

The concept of medication adherence is the degree to which a person's behavior, in relation to the use of drugs, corresponds to the recommendations of a health professional.¹ In this sense, non-adherence is configured in the behaviors of taking the medication at the wrong dose and time, forgetting to take a dose or interrupting treatment early.

Lack of adherence to the treatment affects coping with Chronic Non-communicable Diseases (CNCDs). At the national level, low adherence is consistent with the demographic and epidemiological transition of the Brazilian population, which reflects, respectively, an accelerated population aging and an increase in the prevalence of CNCDs.²⁻³

Among the CNCDs, Arterial Hypertension (AH) gains notoriety for its high prevalence rates. In the capital of Pernambuco, Recife, the prevalence reaches 28.4% of hypertensive individuals.² The disease still presents itself as an important risk factor for the development and complications of cardiovascular diseases and represents one of the main causes of consultation in primary care.⁴⁻⁵

In this context, it must be considered that the problem of AH is not related only to its high prevalence. Non-adherence to the antihypertensive treatment, with rates higher than 35%, has raised growing concerns in the management of the disease.⁶⁻⁸ This fact contributes to high blood pressure levels and to undesirable cardiovascular complications, commonly found in the population.

In addition, some studies have associated to the adherence to the antihypertensive treatment factors such as gender, number of medications in use, adverse reactions, comorbidities, schooling level, marital status, income and age.⁹⁻¹⁶

In view of the current epidemiological scenarios and of the magnitude of AH, as well as the complications arising from the disease, non-adherence to the treatment is an aspect that must be considered in its management. Thus, as a way of directing health care with effective clinical repercussions in the treatment of AH in a population, it becomes relevant to evaluate the hypertensive individuals monitored in primary health care, from the perspective of the adherence to antihypertensive medication, the control of pressure levels and of the factors associated with them, which is the objective of this study.

METHOD

This is a cross-sectional, descriptive, and analytical study. It was developed in the municipality of Recife, whose population was estimated at 1,617,183 million inhabitants in 2015, and a total of 642,856 hypertensive individuals recorded in the same year.¹⁷⁻¹⁸

The population comprised individuals diagnosed with AH, over 18 years of age, recorded and monitored by the program for registering and monitoring patients with AH and/or diabetes mellitus (Hiperdia) in the primary care units of the municipality under study.

From the perspective of health care, Recife is divided into 8 districts. Two health units in each district were randomly drawn for the selection of participants and data collection, totaling 16 units. The sample calculation used the census data of the municipality and was performed in the Epi Info™ software, version 7.2, considering a 95% confidence level. A total of 421 hypertensive individuals were included, selected for convenience, in order to meet the defined inclusion criteria.

Data collection took place through the following instruments: questionnaire with sociodemographic and clinical data, prepared by the researchers; and by a specific self-reported Morisky Medication Adherence Scale-MMAS-8 questionnaire. The latter consists of a scale of eight items classified in 3 categories: scores of 8-high adherence, scores of 6 to 7-medium adherence, and scores below

6-low adherence. This instrument was chosen because it is specific for assessing adherence to antihypertensive medication as well as being indicated after psychometric evaluation and moderate internal consistency in Brazil, with a *Cronbach's alpha* of 0.682.¹⁹⁻²⁰

The verification of blood pressure control was performed from three blood pressure measurements in the office with the individuals seated, with their legs uncrossed, feet resting on the floor, back against the chair, and relaxed. Automatic Omron® sphygmomanometers and cuffs suitable for the circumference of the participant's arm were used. In the measurement, a difference of up to 4 mmHg was sought between the three measurements, with up to five pressure measurements being carried out to reach this standard. The systolic and diastolic pressure value considered was the mean of the three values measured in the individual. The blood pressure measurement techniques followed what is recommended in the 7th Brazilian Guideline for Arterial Hypertension.⁴

In order to minimize biases in measuring the variables, with due regard for the quality of the data collected, a protocol was developed to standardize the application of the collection instruments, as well as the measurement of blood pressure. The interviewers were trained to follow the protocol and were periodically supervised without prior notice in the collection field.

Data analysis was performed using the SPSS statistical software, version 20.0. The continuous variables are presented by measures of central tendency. The categorical variables are displayed in their absolute and relative frequencies.

The statistical test chosen to study the relationship between some variables was the Chi-square. The Odds Ratio (OR) was used to estimate the relative risk, with a 95% confidence interval (95% CI). To study the association between blood pressure control and medication adherence, the Kruskal-Wallis test was used. Statistical significance was considered for $p < 0.05$ (5%).

The realization of this study followed all the ethical precepts of research with human beings, and it was submitted to the Research Ethics Committee of the University of Pernambuco, a public state university.

RESULTS

The sample analyzed was composed of 421 hypertensive individuals, predominantly female (77%), with a mean age of 59.9 (± 11) years old. The afro-descendant ethnicity was the most prevalent (75.3%), as well as a low level of schooling (68.2%). As for income, 72.2% did not have a paid activity and more than half (59.9%) had a monthly income of 1 minimum wage or less. Regarding the clinical aspects, the study participants were categorized according to the classification of pressure levels, antihypertensive treatment time, number of antihypertensive drugs in use, antihypertensive side effects, hypertensive urgency or emergency in the last year, and use of drugs other than antihypertensives. The socioeconomic and clinical data are discussed in Table 1.

Table 1 – Socioeconomic and clinical characterization of the hypertensive individuals monitored in primary care. Recife, PE, Brazil, 2018. (n=421).

Variables	Mean(\pm SD) / Median (min. – max.)	n (%)
Gender	–	
Female		324 (77)
Male		97 (23)
Age	59.9 (± 11)	
≤ 65 years old		288 (68.4)
> 65 years old		133 (31.6)

Table 1 – Cont.

Variables	Mean(\pmSD) / Median (min. – max.)	n (%)
Ethnicity	–	
White		95 (22.6)
Brown		219 (51.5)
Black		100 (23.8)
Indigenous		4 (1)
Other		5 (1.2)
Marital status	–	
Has a partner		210 (49.5)
No partner		211 (50.5)
Paid work	–	
Yes		117 (27.8)
No		304 (72.2)
Income*	954.00 (0.00 – 4,950.00)	
≤ 1 minimum wage		252 (59.9)
> 1 minimum wage		169 (40.1)
Schooling	6 (0 – 17)	
≤ 9 years		287 (68.2)
> 9 years		134 (31.8)
Blood pressure classification	–	
Normal		55 (13.1)
Borderline		150 (35.6)
Stage 1		144 (34.2)
Stage 2		40 (9.5)
Stage 3		30 (7.1)
Unknown		2 (0.5)
Antihypertensive treatment time (months)	120 (6 – 784)	
≤ 60 months		139 (33)
> 60 months		282 (67)
Number of antihypertensive drugs	1 (1 – 5)	
≤ 2 drugs		325 (77.2)
3 or more drugs		96 (22.8)
Antihypertensive side effects	–	
Yes		71 (16.9)
No		350 (83.1)
Hypertensive urgency or emergency in the last year	–	
Yes		107 (25.6)
No		311 (74.4)
Use of other medications	–	
Yes		297 (70.5)
No		124 (29.5)

*Income in reais. The Brazilian minimum wage in force for 2018 (R\$ 954.00) is considered.

Among the 71 hypertensive individuals who reported side effects due to the use of antihypertensive drugs, 43.7% reported an increase in urinary frequency, 19.7% mentioned the sensation of dry oral mucosa, and 36.6% cited non-specific symptoms.

The use of other drugs for continuous use by 70.5% of the individuals was related to the following self-reported conditions: stress (69.6%), dyslipidemia (46.1%), diabetes mellitus (35.4%), alcoholism (16.4%), heart disease (11.9%), smoking (11.4%), stroke (8.6%) and kidney disease (6.2%).

The main drugs used for the treatment of AH were thiazide diuretics; Angiotensin Receptor Blockers (ARBs) and Angiotensin Converting Enzyme Inhibitors (ACEIs). Regarding the medications for the treatment of comorbidities, hypoglycemic agents, statins and psychotropics were the most mentioned.

From the perspective of adherence to antihypertensive drugs, the mean MMAS-8 score was 5.4 (± 1.8). Among the three adherence categories, there was predominance of low adherence, verified in 48.5% of the study participants. Medium and high adherence was present in 38.7% and 12.8%, respectively.

When assessing the frequency of answers to the MMAS-8 items (Table 2), behaviors related to forgetfulness stood out and were evidenced by item 1, in which 53.2% stated that they forgot to take their medications; and in item 8, which also dealt with forgetfulness, but in the sense of the frequency with which the individual found it difficult to remember to take the antihypertensive drugs. In this last item, the answer options were on a Likert scale and only 5.2% stated that they never felt this difficulty.

Table 2 – Frequency of answers of hypertensive individuals to items 1 to 7 of the Morisky Medication Adherence Scale 8. Recife, PE, Brazil, 2018. (n=421).

Questions	Yes	No
1. Do you sometimes forget to take your high blood pressure pills?	53.2%	46.8%
2. Over the past two weeks, were there any days when you did not take your high blood pressure medicine?	34.4%	65.6%
3. Have you ever cut back or stopped taking your medication without telling your doctor because you felt worse when you took it?	20.2%	79.8%
4. When you travel or leave home, do you sometimes forget to bring along your medications?	41.3%	58.7
5. Did you take your high blood pressure medicine yesterday?	90%	10%
6. When you feel like your blood pressure is under control, do you sometimes stop taking your medicine?	13.8%	86.2%
7. Do you ever feel hassled about sticking to your blood pressure treatment plan?	30.4%	69.6%

To analyze some associations by the Chi-square test, the following variables were dichotomized: blood pressure control and medication adherence. In the first, the categories were the following: “normal/borderline”, which grouped individuals with systolic pressure < 120 to 139 mmHg and diastolic pressure < 80 to 89 mmHg; and “altered pressure”, grouping participants with blood pressure ≥ 140 mmHg (systolic) and ≥ 90 mmHg (diastolic) (Table 3).

Table 3 – Blood pressure control of hypertensive individuals monitored in primary care. Recife, PE, Brazil, 2018. (n=421).

Variables	BP control				OR	CI (95%)	p-value [†]
	Normal/ Borderline		Altered				
	N	%	N	%			
Gender							
Female	167	51.5	157	48.5	1.652	1.040 – 2.622	0.033
Male	38	39.2	59	60.8			
Age							
≤ 65 years old	150	52.1	138	47.9	1.542	1.018 – 2.335	0.041
> 65 years old	55	41.4	78	58.6			
Schooling							
≤ 9 years	127	44.3	160	55.7	0.570	0.376 – 0.863	0.008
> 9 years	78	58.2	56	41.8			
Antihypertensive drugs							
≤ 2 drugs	170	52.3	155	47.7	1.912	1.196 – 3.056	0.006
3 or more drugs	35	36.5	61	63.5			
Side Effects							
Yes	26	36.6	45	63.4	0.552	0.326 – 0.934	0.026
No	179	51.1	171	48.9			

*BP: Blood Pressure; †Chi-square test.

Regarding the dichotomization of the outcome variable (adherence), the medium/high adherence and low adherence categories were adopted, and their associations with some independent variables are presented in Table 4.

Table 4 – Drug adherence and socioeconomic and clinical variables of hypertensive individuals monitored in primary care. Recife, PE, Brazil, 2018. (n=421).

Variables	Pharmacological adherence				OR	CI (95%)	p-value [†]
	Medium/High		Low				
	N	%	N	%			
Marital status							
Has a partner	94	44.8	116	55.2	0.580	0.394 – 0.853	0.005
No partner	123	58.3	88	41.7			
Paid work							
Yes	51	43.6	66	56.4	0.642	0.418 – 0.987	0.043
No	166	54.6	138	45.4			
Stress							
Yes	136	46.4	157	53.6	0.503	0.328 – 0.770	0.001
No	81	63.3	47	36.7			
Hypertensive urgency or emergency							
Yes	46	43	61	57	0.625	0.402 – 0.974	0.037
No	170	54.7	141	45.3			

Table 4 – Cont.

Variables	Pharmacological adherence				OR	CI (95%)	p-value [†]
	Medium/High		Low				
	N	%	N	%			
Side Effects							
Yes	27	38	44	62	0.517	0.306 – 0.872	0.012
No	190	54.3	160	45.7			
Use of other medications							
Yes	168	56.6	129	43.4	1.993	1.301 – 3.055	0.001
No	49	39.5	75	60.5			

*Chi-square test

When analyzing the continuous values of systolic and diastolic blood pressure in the low, medium and high adherence groups, there were no statistically significant variations (Table 5).

Table 5 – Evaluation of the blood pressure values as a function of medication adherence of hypertensive individuals monitored in primary care. Recife, PE, Brazil, 2018. (n=421).

Variables	SBP		DBP	
	Median (min. – max.)	p-value [†]	Median (min. – max.)	p-value [†]
Low adherence	138 (102 – 224)	0.364	84 (51 – 148)	0.123
Medium adherence	140 (97 – 213)		81 (52 – 114)	
High adherence	133 (100 – 180)		83.5 (51 – 106)	

*SBP: Systolic Blood Pressure; DBP: Diastolic Blood Pressure. [†]Kruskal-Wallis test.

DISCUSSION

The panorama of the epidemiological transition of the Brazilian population brought with it the need to face the health problems related to CNCDs, including low adherence to the treatment. To this context is added the rapid increase in life expectancy and population aging, which further impacts the prevalence of CNCDs.³

The mean age in this study, below the 6th decade of life, was similar to that found in another study in Brazil that evaluated adherence to the treatment of AH.⁹ Mean ages over 65 years old are verified in studies of developed countries and in some regions of the country with better socioeconomic conditions.^{15,21–22} Such contrasts reinforce the premature aging of the Brazilian population, especially in the North and Northeast regions, and the increasingly frequent reach of CNCDs at younger ages.

The predominant income of up to one minimum wage and low schooling are also a reflection of the social inequalities and, when considering Dahlgren and Whitehead's model of social determination of health,²³ they are located in the layer of living and working conditions. These aspects, added to the higher percentage of hypertensive individuals without work activity, express a profile of social vulnerability in the study population.

With regard to the classification of the blood pressure levels, 50.8% of the sample had values equal to or greater than 140/90 mmHg, which showed lack of blood pressure control in an important number of participants. This percentage was higher than that evidenced by other studies.^{8–9}

A Brazilian study found different means of systolic and diastolic pressure between two groups: one with the “lack of adherence” Nursing diagnosis and the other without that diagnosis. Systolic

pressure was approximately 10 mmHg higher in the first group.²⁴ In addition, higher blood pressure values are verified among hypertensive individuals with low adherence,¹⁵ although there was no significant association in this study.

Also with regard to data on blood pressure control, it was found that male gender, age older than 65 years old, low schooling, use of three or more antihypertensive drugs, and presence of side effects were associated with altered blood pressure.

Regarding the male gender, the association found is consistent with a study conducted with hypertensive Chinese people.¹⁰ This possibly reflects the deficit in self-care in health of this group, a situation that implies little demand for the health service. However, a Brazilian study found that the change in blood pressure was associated with the female gender, attributing to this result a possible relationship between pressure control and sympathetic nervous muscle activity.⁹

The uncontrolled blood pressure associated with older individuals is probably due to the older adults' difficulty in managing their health treatments. However, even with this difficulty, it is reported that the older adults have been more adherent to the antihypertensive medication,²⁵ perhaps due to the feeling of little vulnerability of younger people.

An inverse association between polypharmacy and blood pressure control was found, so that individuals with three or more prescribed antihypertensive drugs were less adherent to the medications. This result corroborates with other studies on adherence to the treatment of AH carried out in the context of primary care^{9,15} and indicates the need to simplify as much as possible complex therapeutic regimens.

The adverse effects were associated with altered pressure and low adherence, corroborating with other studies.^{12,26} It is indisputable that the side effects of the medications imply their discontinued use or even abandonment of the treatment, compromising its mechanism of action and consequently its therapeutic effects. Despite this, no association was found between uncontrolled blood pressure and non-adherence to medication. This finding is probably due to the pressure measurement method, which, although it has followed a standardization, has its limitations when compared to measurements by the Ambulatory Blood Pressure Monitoring (ABPM) exam.

When considering the assessment of medication adherence, the mean score by MMAS-8 was lower than that found in other studies.²⁷⁻²⁸ This difference reflects the individual, institutional and programmatic barriers to adherence to the health treatments,¹ more pronounced in Brazil, a dissimilar context in these studies, carried out in countries with greater socioeconomic development.

Medium/High adherence to antihypertensive pharmacotherapy was associated with job inactivity, similar to that reported by a study in Cali, Colombia.²⁹ This is justified when considering that professional activities take more daily time spent with concerns unrelated to personal life and health treatments.

With regard to the use of drugs for other chronic diseases, this was associated with better adherence. Although the use of multiple drugs may imply low pharmacological adherence,⁶ using drugs for other treatments may have promoted better management of the intake of antihypertensive drugs in the present study.

The association evidenced between low adherence and married individuals is possible due to the predominance of women in the study and to the fact that, culturally, domestic, children and partner care is attributed to the female gender. These occupations can influence self-care in health.

Stress was also significantly associated with low medication adherence, a fact that can be attributed to the daily stressors of low-income populations, as well as to the symptoms of anxiety and depression linked to stress, which are increasingly common among people.

In this context, it should be noted that psychotropic drugs were one of the drugs most used by the participants, predominantly for the treatment of anxiety and depression disorders. In addition,

mental disorders can enhance forgetfulness behaviors in the drug treatment, which represent a risk for non-adherence.³⁰

It is also important to point out the significant association between low adherence in hypertensive individuals who referred an hypertensive urgency or emergency consultation last year. This association verifies that discontinuity in the antihypertensive pharmacological treatment leads to an inadequate control of blood pressure and to an increase in the risks for acute cardiovascular episodes. A study confirms this result, by verifying greater entry into emergency rooms due to acute episodes of hypertensive people not adhering to the treatment.⁸

In the context of primary health care, it is essential to have a Nursing consultation for individuals with arterial hypertension, as it has brought benefits for the treatment. A Brazilian survey showed that enrollment in the Hiperdia program was not associated with greater medication adherence among hypertensive patients. However, better adherence was verified among individuals who attended at least four Nursing consultations during the year.⁸

The execution of this study had limitations regarding the method for measuring blood pressure, not performed by the ABPM, which can reduce the reliability of the results regarding blood pressure control.

CONCLUSION

The results of the study demonstrated a behavior of low adherence to medication in 48.5% of the participants. This outcome was associated with married individuals, in work activity, with self-reported stress, hypertensive crisis in the last year, side effects, and who do not take medication for other chronic diseases.

High blood pressure maintained an association with the male gender, age older than 65 years old, lower schooling, use of more than two antihypertensive drugs, and presence of side effects.

These results show the need to redirect the health care practices for hypertensive people in primary care, so that the health teams seek strategies to overcome low adherence to the treatment, including in groups identified as at risk.

It is worth noting, however, the importance of adopting strategies that consider all the subjectivities behind the low adherence of hypertensive individuals, a factor that can be investigated within the Nursing process and, therefore, should be considered in other studies.

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NOTES

ORIGIN OF THE ARTICLE

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CONFLICT OF INTEREST

There is no conflict of interests.

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