

Quality of life and accession to the pharmacological treatment among elderly hypertensive

Qualidade de vida e adesão ao tratamento farmacológico entre idosos hipertensos
Calidad de vida y adhesión al tratamiento farmacológico entre personas mayores hipertensiva

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ABSTRACT

Objective: to compare variables obtained in adherence and non-adherence to drug treatment for hypertension, according to socioeconomic situation, time of diagnosis, self-reported morbidities, indicative of depression and quality of life. **Method:** cross-sectional analytical study of 524 elderly with adherence and 505 non-adherence to the treatment. A descriptive analysis, Chi-square test and Student t test ($p < 0.05$) were held. **Results:** there was higher proportion of older subjects, indicative of morbidity and depression among those with adherence. Non-adherence subjects had lower scores in all domains and quality of life facets. **Conclusion:** actions favoring the adherence to pharmacological treatment should be recommended, to minimize the impact of comorbidities and improve quality of life.

Key words: Hypertension; Health of the Elderly; Quality of Life.

RESUMO

Objetivo: comparar as variáveis obtidas em situação de adesão e não adesão ao tratamento farmacológico para hipertensão arterial sistêmica, segundo condições socioeconômicas, tempo de diagnóstico, morbidades autorreferidas, indicativo de depressão e qualidade de vida. **Método:** estudo transversal realizado com 524 idosos aderentes e 505 não. Realizou-se análise descritiva, testes Qui-quadrado e *t*-Student ($p < 0,05$). **Resultados:** observou-se entre os aderentes maior proporção de idosos mais velhos, morbidades e indicativo de depressão. Aqueles não aderentes obtiveram escores inferiores em todos os domínios e facetas de qualidade de vida. **Conclusão:** devem-se preconizar ações que favoreçam a maior adesão ao tratamento farmacológico, visando minimizar o impacto das comorbidades e melhorar a qualidade de vida.

Descritores: Hipertensão; Saúde do Idoso; Qualidade de Vida.

RESUMEN

Objetivo: comparar las variables obtenidas en el estado de cumplimiento y la no adhesión a al tratamiento farmacológico de la hipertensión, de acuerdo con las condiciones socioeconómicas, momento del diagnóstico, morbilidades auto-reporte, indicativo de la depresión y la calidad de vida. **Método:** estudio transversal con 524 miembros y 505 ancianos no. Una prueba de la *t* análisis descriptivo, prueba de Chi-cuadrado y Student ($p < 0,05$). **Resultados:** se observó entre los abonados mayor proporción de sujetos de edad avanzada, indicativos de la morbilidad y la depresión. No conforme con puntajes más bajos en todas las áreas y facetas de la calidad de vida. **Conclusión:** se debe promover acciones que favorezcan el más alto es el tratamiento farmacológico para reducir al mínimo el impacto de las comorbidades y mejorar la calidad de vida.

Palabras clave: Hipertensión; Salud del Anciano; Calidad de Vida.

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INTRODUCTION

Scientific literature has highlighted that systemic hypertension (SH) is the most prevalent morbidity among the elderly, above 50%, and being one of the leading causes of death⁽¹⁾.

The correct diagnosis and monitoring persistence are relevant factors to achieve the goal in the treatment and reduce cardiovascular morbidity and mortality. In this context, it is noteworthy that non-adherence to treatment has been identified as the main cause of uncontrolled blood pressure⁽²⁾.

A study conducted among elderly hypertensive people in Fortaleza showed that 96.5% reported to follow the treatment, however, requiring guidelines⁽³⁾. A survey conducted among elderly hypertensive patients in a primary care unit in Maranhão showed that 60.6% were adherent, 31.8% loosely adherent and 7.6% were non-adherent to drug therapy⁽⁴⁾.

Despite many advances in the SH treatment, success in controlling the disease in practice is limited. A survey conducted in New York showed that individuals with serious concerns about their medications tend to have lower medication adherence⁽⁵⁾.

It is noted that several factors have been associated with poor adherence to drug treatment. A review study showed that five groups of factors influence adherence to treatment among elderly hypertensive: therapeutic regimen; socioeconomic and demographic aspects; services and health professionals; psychosocial and cultural aspects; and family and social support. It is noteworthy that the male and elderly with low income are the most vulnerable population⁽⁶⁾.

Among the elderly hypertensive patients in a survey conducted in Maranhão, the lower adherence was related to low education⁽⁴⁾. However, in a survey conducted in Santa Catarina, the authors observed no relationship between medication adherence and gender, income, marital status and occupation, among the elderly with hypertension⁽⁷⁾.

Negative psychological aspects of hypertension are also highlighted in a survey in Minas Gerais⁽⁸⁾, caused by regular use of antihypertensive medications that can contribute to sadness and dissatisfaction with the difficulty of controlling blood pressure, suggesting their relationship with clinical depression.

In addition, it is known that SH, often silent, may have a negative effect on quality of life (QOL) in the affected subject⁽⁹⁾. A survey among elderly people with hypertension in the United States observed lower QOL scores associated with lower levels of adherence to antihypertensive medication⁽¹⁰⁾. Based on the above, it is observed a gap on the relationship between medication adherence and QOL of elderly people, which is measured by a specific instrument. There is also the divergence of the influence of socioeconomic factors in treatment adherence among elderly patients with SH. Thus, the objective of this study was to compare the elderly adherent and non-adherent to drug treatment for SH, according to socioeconomic variables, time of diagnosis of hypertension, self-reported morbidities, indicative of depression and QOL.

METHOD

This study was preceded by the Research Ethics Committee with Humans approval from Universidade Federal

do Triângulo Mineiro. The elderly were approached at their homes, it was presented the research objectives and Free Consent Term and Informed.

It is a household survey, with cross-sectional, observational and analytical design, developed in the city of Uberaba-MG, and it is part of a research project entitled "Morbidity, quality of life and functional capacity of elderly people", carried out by the Research Group on Public Health of the Federal University of Triângulo Mineiro (UFTM).

For the sample, it was used a list containing the name and address of the elderly who participated in the two previous studies in 2005 and 2008, conducted by the Research Group on Public Health/UFTM. In previous projects, to calculate the sample 95% confidence was considered, 80% of test power, error margin of 4% for interval estimates and a ratio of $\pi=0.5$ for the proportion of interest. The initial sample consisted of 3.034 elderly; however, with the losses obtained in 2012, resulted in 2.116 elderly. Among them, there were 1.691 elderly interviewed, being 265 canceled due to death and 160 for cognitive decline.

In this study, it was considered the following inclusion criteria: people aged 60 years old or older, living in the urban area of the city of Uberaba-MG, which showed no cognitive decline and that self-reported SH. There were excluded those who did not report SH ($n=640$) or did not respond to Morisky and Green tests ($n=22$). Thus, 1.029 elderly participated.

Interviewers were selected, with previous experience in data collection and who were trained by the main researcher on how to approach the elderly, the application of instruments and ethical principles that involve research. Data collection occurred in the elderly's homes and the interviewer had as a reference list containing the name and address from the previous project. The interviews were reviewed by field supervisors and, when there was inconsistent data, the interview was returned to the interviewer so he could get back in touch with the elderly again and complete it properly.

Before starting the interview, the Mini Mental State Examination was applied to assess cognitive ability. The translated version and validated was used in Brazil⁽¹¹⁾.

To assess the socioeconomic profile and self-reported morbidities, an instrument built by the Research Group on Public Health/UFTM used in previous research since 2005 was used.

To verify adherence to pharmacological treatment for SH, the Morisky and Green Test were applied. The result ranges from 0 to 4, in which 4 means more adherent and those with 3 or less points were non-adherent⁽¹²⁾.

The Abbreviated Geriatric Depression Scale was also applied to measure the presence of indicative of depression. The version validated in Brazil was used⁽¹³⁾. This scale consists of 15 closed questions with objective answers (yes or no). It is considered positive screening for depression when the score is greater than five points⁽¹³⁾.

Evaluation of quality of life was carried out by two instruments: the World Health Organization Quality of Life Bref (WHOQOL-BREF), abbreviated version, which has 26 questions; two are general and 24 had the four QOL domains: physical, psychological, social relationships and environment⁽¹⁴⁾. The

World Health Organization Quality of Life Old (WHOQOL-OLD) consists of 24 items of Likert scale assigned to six facets: sensory abilities; autonomy; past, present and future activities; social participation; death and dying; and intimacy⁽¹⁵⁾.

Although the questionnaires can be self-administered, it was decided to interview them because of possible difficulty of reading or understanding the items outlined in the questionnaire, as well as potential vision problems presented by the elderly people.

The variables considered in this study were socioeconomic - gender; age group in years; marital status; education in years of study; individual income in minimum wages; time of diagnosis of SH in years; self-reported morbidity; adherence to pharmacological treatment for SH; discontinuation of treatment and reason; indicative of depression; QOL domains and facets of the WHOQOL-BREF and WHOQOL-OLD.

From collected data two groups were created: Group 1 (elderly adherents to drug treatment for SH, n = 524) and Group 2 (elderly who do not adhere to drug treatment for SH, n = 505).

An electronic spreadsheet in Excel® program was built. The collected data were processed on a microcomputer by two researchers, with double entry, and subsequent verification of the existence of inconsistent records. Then, it was proceeded to verify the consistency between the databases. When inconsistent data were identified, the original interviews were revised and the correction was performed. The database was transported to the software Statistical Package for Social Sciences (SPSS), version 17.0, continuing with data analysis.

The statistical analysis was held through the distribution of absolute frequencies and percentages for categorical variables and measures of centrality (average) and dispersion (standard deviation) for numerical variables. To compare the variables, the chi-square test for categorical variables and Student t test for numerical variables ($p < 0.05$) were applied.

RESULTS

Among 1,029 elderlies interviewed, 50.9% adhered to pharmacological treatment for SH and 49.1% did not adhere to the treatment.

In both groups there were more female ($\chi^2=0.170$; $p=0.680$), married or living with a partner ($\chi^2=3.550$; $p=0.314$), four to seven years of study ($\chi^2=3.796$; $p=0.434$) and monthly individual income of one minimum wage ($\chi^2=6.015$; $p=0.305$). There were more elderly people being 70-80 years old; however, there were older elderly among the adherents of pharmacological treatment (22.3%) when compared to non-adherents (16.8%) ($p=0.031$).

The average of SH diagnosis time was similar in both groups, corresponding to 14.95 years (SD = 11.50) in adherents and 15.52 (SD = 12.1) among non-adherent ($t=0.246$; $p=0.437$).

The non-adherent elderly to drug treatment had a higher number of comorbidities ($\mu = 6.58$, SD = 3.0) than the adherent ($\mu = 5.86$, SD = 3.14) ($t = -3.724$, $p < 0.001$).

Among those who did not adhere to drug treatment, compared to those who adhere, there was a higher proportion of those who self-reported: rheumatism (22.2% vs 15.6%; $p=0.007$); poor circulation (48.1% vs. 40.6%; $p=0.016$); constipation (28.7% vs 19.5%; $p=0.001$), kidney problems (17.0% vs 9.0%; $p < 0.001$) benign tumors (3.2% vs 1.1%; $p=0.025$), vision problems (54.3% vs 46.5%; $p=0.012$) and indicative of depression (35.8% vs 23.9%; $p < 0.001$), respectively.

Among adherents, 6.9% and 25.5% of non-adherents reported having already discontinued treatment. The most common reasons among the adherents were to find that they were cured (16.7%), not feeling anything (8.3%), not feeling the need for treatment (8.3%); and for adherents: not feeling anything (16.3%) believe that it should take the medicine only when they felt ill (14%) and forgetfulness (10.9%).

In both groups, the highest percentage assessed their QOL as good (50.4% of the adherents and 48.3% among non-adherents). Most of them were satisfied with their health, with 48.9% of the adherents and 36.6% of non-adherents.

When applying the WHOQOL-BREF, in both the lowest score was found in the physical domain and the biggest in social relations; non-adherents elderly had significantly lower scores on the physical, psychological, social relationships and environment (Table 1).

Table 1 - Distribution of median and standard deviation of domains and facets scores of quality of life according to adherence for treatment, Uberaba, Minas Gerais, Brazil, 2012

	Yes		No		t	p value
	Average	SD	Average	SD		
WHOQOL-BREF						
Physical	60.99	17.31	55.88	17.46	4.708	<0.001*
Psychological	66.58	15.60	62.46	15.94	4.191	<0.001*
Social relationships	72.72	13.02	68.72	14.84	4.586	<0.001*
Environment	62.02	14.54	57.34	13.47	5.348	<0.001*

Continues

Table 1 (cont.)

	Yes		No		t	p value
	Average	SD	Average	SD		
WHOQOL-OLD						
Sensory abilities	73.04	23.30	66.13	23.28	4.763	<0.001*
Autonomy	68.06	31.06	62.05	31.42	3.080	0.002*
Past, present and future activities	70,0	29.49	65.27	29.82	2.558	0.011*
Social participation	65.17	16.62	60.44	31.23	3.048	0.002*
Death and dying	73.88	37.30	72.50	25.36	0.691	0.490
Intimacy	72.58	33.44	67.38	19.81	3.022	0.003*

Note: * $p < 0,05$

The lowest scores in WHOQOL-OLD, were found in the facet of social participation and the biggest in death and dying in both groups; non-adherents elderly had lower scores in sensory abilities, autonomy, past, present and future activities, social participation and intimacy (Table 1).

In Table 1 there are the average and standard deviation of QOL scores according to domains and facets.

DISCUSSION

This research corroborates a study conducted with elderly people with SH, enrolled in a family health care facility of São Luís-MA, and found that the highest percentage adhere to drug treatment (60.6%)⁽⁴⁾.

Thus, as in this study, a research of adults and elderly with SH of a Family Health Strategy (ESF) of Londrina-PR also showed no association between genders and adherence to pharmacological treatment ($p = 0.060$), which prevailed women in both groups⁽¹⁶⁾.

Regarding to marital status, a survey conducted with elderly people in Tubarão-SC identified a higher percentage of married in both groups, no significant association with adherence to pharmacological treatment for SH ($p = 0.068$)⁽⁷⁾ and this research. Even with these results, it should be noted that the scientific literature indicates that the family often represented by the spouse, has a fundamental role in adherence to pharmacological treatment for SH as well as in adapting to changes in lifestyle imposed by the disease⁽¹⁷⁾.

In the study of Londrina, education also was not associated with adherence to pharmacological treatment ($p = 0.167$)⁽¹⁶⁾. However, an integrative review study identified in national and international literature that low educational levels may be associated with lower adherence to pharmacological treatment for SH⁽⁶⁾. Elderly with few years of education or illiterate may have difficulty understanding the written prescriptions, thus affecting adherence to treatment⁽¹⁷⁾. Thus, health professionals should guide clearly and simply prescriptions, considering the level of education of the elderly.

Similar with the results of this research, in the study conducted in Tubarão-SC, income was not associated with adherence to pharmacological treatment for SH in the elderly ($p = 0.800$)⁽⁷⁾. It

is possible, though not investigated, the free supply of medicine by the National Health System, favoring this result. Moreover, national studies of elderly point out that the lower the socioeconomic status, the lesser knowledge about the disease and more difficult access to health services, which could reflect in lower adherence to pharmacological treatment^(6,17).

A research conducted in Londrina-PR also highlighted the association of adherence with pharmacological treatment for SH with increasing age ($p < 0.001$)⁽¹⁶⁾. With aging, people become more susceptible to chronic diseases, which can cause major concern with their health situation and influence the better/greater adherence to pharmacological treatment for SH⁽¹⁶⁾, justifying the data found in this study.

As for the time of SH, a study conducted in Tubarão-SC with elderly people with SH found that the average of SH diagnosis time was similar among those adherents (11.5 ± 9.8 years) and non-adherents (10.5 ± 8.3 years) to treatment for SH⁽⁷⁾, being similar to this research.

Corroborating also the results of this study, a research conducted with adults and elderly from data from the National Survey by Household Sample (PNAD) showed a lower proportion of non-adherent to pharmacological treatment for SH among those who had more comorbidities ($p < 0,0001$)⁽¹⁸⁾. However, the presence of comorbidities may lead to the increased use of medication by the elderly and more medication doses that together with inadequate knowledge about the therapy can hamper treatment adherence.

Health education can be a useful tool to minimize or avoid the impact of these factors on adherence to medicine for SH⁽⁶⁾. Thus, it is important for nurses to perform follow-up actions and monitoring the health of the elderly in order to contribute to identify difficulties about the adherence and to provide guidance.

Regarding the association between comorbidities, it is noteworthy that SH is common among individuals with arthritis. It is noteworthy that autoimmune diseases such as rheumatoid arthritis are characterized by chronic inflammation of various parts of the body, reaching the cardiovascular system. Thus, it appears that the results of this study may be related to this fact; that is adherents would have less control of the disease, contributing to the presence of arthritis. It is important

that elderly people who present other chronic disease, such as rheumatism, and use multiple medications are accompanied by the health team and advised on the relationship between arthritis and SH, emphasizing the need to proceed with the proposed treatment.

The relationship between SH and circulatory problems such as varicose veins, is described in the scientific literature. In a study developed with elderly people, it was found that those with other health problems, such as circulation problems (varicose veins), tended to value less the medication treatment for SH⁽¹⁹⁾ and may justify the results obtained in this study. It is noteworthy also that the investigation of comorbidities and polypharmacy should be carried out by the health team, in order to facilitate monitoring of the therapeutic plan to be followed by the elderly.

As for constipation, a national study found that there is less consumption of fruits and vegetables among those who do not adhere to pharmacological treatment for SH⁽²⁰⁾ and can justify this result. However, it is necessary other studies to elucidate this relationship. It is noteworthy that the low intake of fiber in foods, can cause health problems such as constipation⁽²¹⁾. Although not investigated, there is possible lower intake of these foods, high in fiber, among non-adherent elderly to treatment for SH may have contributed to the higher proportion of constipation cases.

It is highlighted the importance of appropriate follow-up of therapy for SH as a favorable factor to the reduction of complications, such as kidney problems⁽³⁾. From this perspective, the nurse should guide and carry out monitoring of the elderly with SH, to adequate adherence to medication use. In individuals with chronic kidney disease in the early stages, strict BP control can be quite effective for non-progression of renal damage. However, those who already have protein loss need strict and proper establishment of antihypertensive medication⁽¹⁾. Considering these factors, it is assumed that the subjects in this study who reported the presence of kidney problems were not properly adhering to medication treatment for SH.

It is noteworthy that hypertension is a highly prevalent morbidity and often this disease is treated without further specific investigation of the causal factors. In this case, there is the presence of tumors, usually benign, such as pheochromocytoma, being secondary causes of SH. Therefore, it is possible, although not investigated that non-adherent elderly for SH treatment may have limited access, or be less frequent to health services, so the relationship between SH and the presence of benign tumors has not been investigated or the proper treatment for tumors had not yet been established. A research is suggested between the two morbidities in order to prevent complications.

In this research, a higher proportion of elderly with vision problems was identified among those who did not adhere to treatment for SH. It is suggested that visual deficiency may favor the discontinuation of treatment, by the difficult to see the schedule for the medication and identification of medication and appropriate dose. Thus, it is important that the vision problem is identified and corrected or mitigated early. The support of family is also important to assist and supervise the elderly⁽²²⁾, especially among those experiencing visual problems in the proper use of medicines for SH, whenever necessary.

Consistent with this research, an international study of elderly patients with SH in the US found that the presence of indicative of depression was associated with low adherence to pharmacological treatment ($p < 0.01$)⁽²³⁾. In the same study, the authors report that low social support may have negatively influenced the adherence to pharmacological treatment⁽²³⁾. Moreover, although it has not been the focus of this research, it is possible that the presence of depressive symptoms interfere in stimulating self-care, impacting adherence to pharmacological treatment. In this sense, the healthcare team should early investigate the presence of depressive symptoms among elderly people with SH, in order to minimize health risks and identify support networks for the elderly with chronic disease to encourage them to adhere the appropriate use of medication.

Regarding to the discontinuation of treatment for SH, a research conducted in public service in Ribeirão Preto-SP found that 58% had adverse effects and 48% reported forgetting to take antihypertensive medication among adherent and non-adherent to the treatment for SH⁽²⁾, diverging from the present study.

Although it has not been the target of this investigation, it is suggested to simplify the treatment as a strategy to provide increased adherence, but the number of associates and different morbidities and medicines used may influence adherence to treatment for SH due to therapy complexity⁽²⁾. In this study, there was a higher number of associated morbidities for those who did not adhere to medicine treatment.

Regarding the self-assessment of QOL and satisfaction with health, such a result can be explained by the fact that QOL is influenced by multiple factors, not being related only to the membership. The self-assessment of health among the elderly does not preclude satisfaction with QOL⁽²⁴⁾.

In the evaluated domains by WHOQOL-BREF, the lowest scores for the physical domain can be associated with effects of anti-hypertensive medication, which among other symptoms can cause pain, fatigue and sleep disorders⁽⁹⁾. The nurse can encourage participation in groups as well as encourage the practice of physical activity for better blood pressure control, helping to reduce pain and discomfort⁽²⁴⁾, enabling to improve these aspects.

The highest score in the social relationships domain to both groups can be justified due to be established and built satisfying relationship with family, friends and health professionals throughout their lives and valued at that stage⁽²⁵⁾. The elderly were found to have own knowledge, expectations, values and individual experiences due to different living conditions and health. These factors may influence adherence or not to medicine treatment for SH. Thus,, the health team must consider and appreciate these aspects⁽²²⁾, which may reflect positively in social relationships.

Comparing the groups, the lowest score in the physical domain among those non-adherent was similar to an international study that identified among the elderly with SH the lowest level of medication adherence associated with lower scores on the physical component⁽¹⁰⁾. Although it has not been the subject of this study, the more control of the disease through medicine treatment, it can favorably impact the QOL⁽²⁴⁾. It is believed that this could be explained by the lower

involvement of elderly people who adhere to treatment of SH by other chronic diseases, which can influence the physical domain, since multiple morbidities may limit the functionality of the elderly⁽²⁶⁾. In this context, it is reinforced the need to investigate aspects committed in this domain in order to develop strategies to minimize its impact.

Referring to the psychological domain, a research conducted in the US found that elderlies who had lower adherence to antihypertensive medication had lower scores on the mental component⁽¹⁰⁾, consistent with this investigation. Considering the higher prevalence of indicative of depression among non-adherent elderly in this investigation, it appears that this fact can result in a lower commitment to treatment because of the change of emotional state. The nurse can create strategies that aim to identify the components involved in this domain to develop actions to support and psychological monitoring by the interdisciplinary team to better adherence to medicine treatment.

For the social relationships domain, a research on elderly people with SH in the United States found that non-adherent to treatment subjects had lower social support⁽²⁴⁾, being similar to this result. Emotional changes and nervousness of some elderly affect social relationships and lead to lower adherence to treatment of SH⁽¹⁰⁾. Such changes can be supported by trusts, developed by the educator and motivator role of the health professional.

It should be emphasized that the support network represented by social relationships can promote to improve health and greater adherence to medicine therapy⁽²²⁾. Health education is highlighted in this context, strengthening links between health professionals, family and elderly, favoring personal relationships and trust, in order to clarify the SH, guiding for the risks of non-adherence to medicine treatment, as well as possible complications arising from no control of SH.

The lowest score in the environment among the adherents cannot indicate greater difficulty in lifestyle changes that require daily adjustment⁽²⁴⁾, such as dietary changes and physical activity. Also the complex and costly therapy, which may not be compatible with the economic reality of individuals, especially for those with multiple chronic morbidities⁽¹⁾, considering the greater number of diseases among non-adherents in this study. Thus, compounds medications may be indicated in general not available for free in public services, reflecting negatively on financial resources, valued item in this domain⁽¹⁴⁾.

The lowest score in social participation in both groups may be due to change in eating routine, self-care and medicine treatment, which can influence the participation of social events in order to avoid foods that influence blood pressure control⁽²⁷⁾, impacting negatively participation in daily activities, especially in the community, being an aspect examined in this facet⁽¹⁵⁾. Thus, the participation of health groups and sharing fears and insecurities can facilitate exchanges of experiences and coping strategies of situations experienced.

The highest scores on the facet of death and dying to both groups can be justified due to the higher percentage of 70-79 years old elderly. It is believed, at this age they have a greater reflection on the finitude of life. A survey conducted with individuals aged 75 years old and older in Tocantins showed

that most respondents are not frightened to death, but with other issues such as serious illness causing physical and psychosocial dependence⁽²⁶⁾.

The lowest score on the facet sensory abilities among the elderly non-adherent to treatment, although not investigated, may be related to higher visual loss identified by self-report of the elderly, a fact that may interfere with the self-care and medicine treatment. Visual problems can affect both the understanding of the treatment as the correct use of the product, such as the time and name of the medication⁽¹⁷⁾. In this way, nurses can use educational strategies to clarify impaired sensations, either from the physiological changes, either of antihypertensive medications, allowing adjustments to losses and constituting a support network for these elderlies. However, it is stressed the need to investigate this aspect of anti-hypertensive therapy.

Concerning the facet of autonomy, it is emphasized that chronic disease and other morbidities require more health care for the elderly, which can take the family to interfere in the decision-making of the elderly and contribute to less autonomy and no motivation for self-care⁽²⁸⁾. It is noteworthy that among the elderly who do not adhere to medicine treatment, more associated morbidities requiring more health care were identified. Thus, investigating the actions of self-care and support them in improving the independence of older people in family and society⁽²⁸⁾, becomes a priority for the nursing care and health team.

As for facet of past, present and future activities, the greatest impact may be related to the higher percentage of elderly patients with multiple comorbidities and indicative of depression that would ease their prospects for the future, measured aspect in this facet⁽¹⁵⁾. Thus, higher spending on health among non-adherent elderly people can result in lower scores in this facet. In addition, it can be reflected on the difficulties that hypertensive patients have in adopting control measures, requiring commitment and persistence⁽²⁹⁾, which may be affected by psychological aspects. In this sense, the care of the family health team, which includes home visits, and medical and/or nursing visits are strategies that can facilitate the effective adherence process, minimizing the impacts for both the health system and for the patients⁽²⁹⁾.

Regarding the facet of social participation, the lowest score among elderly people who did not adhere to treatment may also be related to higher self-reported health problems, which can be considered limiting for participation in certain activities. Multiple morbidities and their consequences, such as physical, emotional and social impairment, may interfere with routine activities of the elderly⁽²⁶⁾. Moreover, relationships acquired throughout life can be strengthened in this phase, such as family, religious and health services ties⁽²⁶⁾ and can be decisive in the search for social activities. In this context, it is emphasized that group activities contribute to the socialization of the elderly as well as for interaction with people who experience the same difficulties. It is a way of overcoming the problems and could encourage coping with chronic illness, treatment and better medication adherence⁽²⁵⁾.

Regarding the intimacy facet, it is emphasized that the antihypertensive medication can cause side effects that compromise QOL⁽²⁰⁾. This facet assesses the ability to have personal

and intimate relationships⁽¹⁵⁾, especially for families. It is clear that family support through relationships of trust and encouragement becomes essential to face SH, increasing confidence⁽²²⁾ and consequently interfering positively in the QOL.

In this context, the activities related to the health of elderly involving family area highlighted. Sharing doubts and experiences can guide health professionals involved in the care of the elderly. Thus, those non-adherent can be identified and, through individual consultation, clarify them about the risks and raise awareness of the correct adherence to therapy, also addressing the benefits for health and QOL.

CONCLUSION

From the results obtained, there is the need for health actions aimed at early identification of health problems and complications that may negatively impact adherence to pharmacological

treatment for SH, such as the presence of comorbidities. It is emphasized the importance of monitoring these elderly individually or through groups offered in health services, such as HiperDia, encouraging greater understanding of the disease and adherence to pharmacological treatment. The family should also be involved in this process, assisting the elderly if necessary, correctly and encouraging them to use medicine prescription for SH, and provide emotional support for the adjustments in lifestyle.

Due to the cross-sectional design of this study, it is not possible to establish a cause and effect relationship between the associated variables; however, it was possible to increase knowledge of the factors that can contribute to lower adherence to pharmacological treatment for SH in the elderly investigated. Thus, these results may provide an insight to the design of health in specific actions aimed at maintaining pharmacological therapy for SH.

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