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Functional health literacy in older adults with hypertension in the Family Health Strategy

Letramento funcional em saúde de idosos com hipertensão arterial na Estratégia de Saúde da Família

La alfabetización funcional de adultos mayores con hipertensión en la Estrategia de Salud Familiar

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ABSTRACT

Objective: To assess Functional Health Literacy and the associated sociodemographic, health, information sources and health media factors in older adults with hypertension assisted at the Family Health Strategy. **Methods:** A quantitative cross-sectional study with an exploratory-descriptive approach, carried out with a total of 264 older adults. A sociodemographic and health characterization instrument was used for the data collection, and another one that evaluated the Functional Health Literacy. For the analysis, a descriptive and inferential statistics were performed. **Results:** Most of the participants in the study had inadequate literacy (59.5% - 157), and the variables education, income, hospital stay and internet as a source of information are related to the averages of Functional Health Literacy. **Conclusion:** Knowing the Functional Health Literacy of older adults with hypertension and its associated factors can provide subsidies for the planning of health education strategies that, in fact, meet their health needs.
Descriptors: Aged; Health Literacy; Hypertension; Family Health Strategy; Nursing.

RESUMO

Objetivo: Avaliar o Letramento Funcional em Saúde e os fatores sociodemográficos, de saúde, fontes de informação e meios de comunicação em saúde associados em pessoas idosas com hipertensão arterial atendidas na Estratégia de Saúde da Família. **Métodos:** Estudo quantitativo transversal com abordagem exploratória-descritivo, realizado com 264 pessoas idosas. Utilizaram-se para a coleta de dados um instrumento de caracterização sociodemográfica e de saúde, e outro que avaliou o Letramento Funcional em Saúde. Para análise, foi realizada estatística descritiva e inferencial. **Resultados:** A maioria dos participantes do estudo obteve letramento inadequado (59,5% - 157), sendo as variáveis escolaridade, renda, internação hospitalar e internet como fonte de informação relacionadas com as médias de Letramento Funcional em Saúde. **Conclusão:** Conhecer o Letramento Funcional em Saúde de pessoas idosas com hipertensão arterial e seus fatores associados pode trazer subsídios para o planejamento de estratégias de educação em saúde que atendam, de fato, as suas necessidades em saúde.
Descritores: Idoso; Alfabetização em Saúde; Hipertensão; Estratégia Saúde da Família; Enfermagem.

RESUMEN

Objetivo: Evaluar el Alfabetismo Funcional en Salud y los factores sociodemográficos, sanitarios, fuentes de información y medios de comunicación sobre salud, asociados a los adultos mayores con hipertensión, que se atienden conforme la Estrategia de Salud Familiar. **Métodos:** Se trata de un estudio cuantitativo transversal con enfoque exploratorio-descriptivo, realizado entre 264 personas de edad avanzada. Para la reunión de datos se utilizó un instrumento de caracterización sociodemográfica y sanitaria, y otro que evaluaba la Alfabetización Funcional en Salud. El análisis se realizó con las estadísticas descriptiva e inferencial. **Resultados:** La mayoría de los participantes del estudio poseía una alfabetización funcional inadecuada (59,5% - 157), teniendo como fuente de información las variables: escolaridad, ingresos, estancia en el hospital e Internet. **Conclusión:** Conocer la Alfabetización Funcional en salud de adultos mayores con hipertensión y sus factores asociados facilitará la captación de recursos para la planificación de estrategias de educación sanitaria que realmente satisfagan sus necesidades de salud.
Descriptores: Adulto Mayor; Alfabetización en Salud; Hipertensión; Estrategia de Salud Familiar; Enfermería.

INTRODUCTION

The relative growth of chronic conditions, especially Noncommunicable diseases (NCDs)[1], is associated with an increase in the older adults population. NCDs are responsible for 38 million annual deaths, with 75% of this total occurring in low and middle income countries, such as Brazil. In this countries, access to preventive health and treatments for these diseases is limited, which results in a greater number of deaths before the age of 70 years old, contributing to a shorter life expectancy[2].

Hypertension is the noncommunicable disease that most affects the older adults, present in more than 60% of this group. It is a multifactorial clinical condition characterized by sustained elevation in blood pressure levels greater than 140 and/or 90mmHg, frequently associated with metabolic disorders, functional and/or structural changes in target organs. In addition, it can be aggravated by other risk factors, such as age, gender, ethnicity, overweight and obesity, salt intake, alcohol, physical inactivity, socioeconomic factors, dyslipidemia, diabetes mellitus and glucose intolerance[3].

As it is a silent disease linked to multiple risk factors, the early diagnosis of hypertension, as well as knowing the factors involved, is extremely important to ensure the best treatment option and greater disease control, in order to reduce hospitalizations and complications resulting from this pathology[4].

Thus, older adults with chronic conditions, such as hypertension, need permanent care, such as monitoring by a health professional, and contributing to the understanding of pharmacological and non-pharmacological guidelines and prescriptions. In addition, they also need a more adequate and effective approach, which focuses on the characteristics and particularities of each individual, so that health guidelines reduce or exclude possible complications that may compromise active aging. Thus, it is necessary to assess Functional Health Literacy (FHL), since understanding health information may interfere with clinical outcomes[5].

FHL is defined as the ability to understand, interpret and apply health information in a written, spoken or digital way[6]. Unlike initial reading instruction, whose concept is related to the acquisition of reading and writing skills, literacy goes further, encompassing the appropriation, use and development of these skills throughout life[7]. Thus, we opted to use the concept of FHL instead of health initial reading instruction, as we understand that literacy goes beyond it.

Individuals with satisfactory FHL tend to have better health outcomes, as they have a greater understanding of the importance of adopting preventive measures and find it easier to understand instructions about medications[6,8]. So, in a study carried out in Picos-PI, which assessed the FHL of adults with and without hypertension, it was observed that the inadequate or marginal FHL had a higher percentage among adults with hypertension in the three Primary Health Center (71.5%; 77.8%; 85.2%)[9]. A study carried out in Iran, with people with an average age of 60.58 years old, showed that there is an association between FHL and knowledge among patients with hypertension[10]. On the other hand, no studies were found that corelated hypertension and FHL, specifically with older adults in Brazil or in the international context.

In addition, primary health care is the first level of care, characterized by a set of actions developed individually and collectively, which include health promotion, protection, rehabilitation and maintenance, as well as the prevention of diseases, their diagnosis and its treatment[11]. Thus, the nurse's performance corresponds to the new care model, not being focused on clinic and healing, but, mainly, built through interpersonal relationships of dialogue, listening, humanization and respect. This new model focuses on the users participation in their proper treatment, decision-making and self-care, so that prevention, diagnosis, monitoring and control of chronic diseases such as hypertension are achieved[9,12].

Therefore, it is important to assess the FHL of older adult with hypertension, especially in primary care, so that nurses and other professionals, who are multipliers of knowledge, can carry out their health education activities from what this population knows about hypertension. It is believed that, by doing this, they will focus on the real needs of this population, allowing them to better manage the continuous care necessary for their chronic condition. Therefore, the study question is: what are the degrees of Functional Health Literacy and the sociodemographic and health factors, sources of information and associated health media in older adults with hypertension assisted in the Family Health Strategy?

OBJECTIVE

To assess Functional Health Literacy and the associated sociodemographic, health, sources of information and health media factors in older adults with hypertension assisted in the Family Health Strategy.

METHODS

Ethical aspects

The ethical precepts of research with human beings were respected, according to Resolution 510/2016. The project for this study was approved by the Research Ethics Committee (REC) of the Federal University of Rio Grande.

Design, setting of study and period

This is an observational study guided by the STROBE tool[13]. This study is part of the macroproject "Association among Functional Health Literacy, medication adherence and functionality in older adults from the family health strategy", carried out in 10 centers, totaling 17 teams of the Family Health Strategy (FHS), which forms the west zone of the city of Rio Grande-RS. This area was chosen because it has 100% coverage of the FHS, whose focus is on health promotion and disease prevention, justifying the extreme importance of knowing the FHL.

Population, sample, inclusion and exclusion criteria

The population selected for the study was composed by older adults registered in the 17 FHS teams. The following inclusion

criteria were used: being aged 60 or over; being assigned to the coverage area of the Family Health Unit; referring to medical diagnosis of hypertension; having at least one year of self-reported education, as recommended by FHL assessment studies[13-17].

The exclusion criteria were: not being able to read the Jaeger Card at 20/40 level, which is considered normal for peripheral vision with or without corrective lenses or glasses; not hearing the whisper on the right and left sides of the ear canal by the Whisper Test; and having a score lower than the cut-off point in the Mini-Mental State Examination (MMSE). The cut-off points in the MMSE were the following: 1 to 3 years of education ≥ 23 points; 4 to 7 years of education ≥ 24 points; < 7 years of education ≥ 28 points[15]. The Jaeger Card, Whisper Test and Mini-Mental State Examination instruments were used as recommended by FHL assessment studies[13-17].

In 2017, the estimated population of the city was 208 thousand inhabitants[18]. The calculation of the estimated older adult population for the area covered by the study was performed based on the percentage of this population segment in the city of Rio Grande/RS, which, according to the last demographic census, is 13.89%[18]. From the population of the 17 teams included in the study (68000), the percentage of older adult population (13.89%) was calculated, resulting in approximately 9445 older adults. Of these, the percentage of hypertensive older adult was calculated based on data from VIGITEL 2017, referring to 2016, which indicated that 60.9% of adults aged 65 and over reported the diagnosis of hypertension in telephone survey. Thus, the study population estimated 5752 older adults with hypertension[19].

We used the sample calculation formula for finite population [20]:

$$\mathbf{n} = (\mathbf{Z}^2 \times \mathbf{P} \times \mathbf{Q} \times \mathbf{N}) / (\mathbf{e}^2 \times (\mathbf{N}-1) + \mathbf{Z}^2 \times \mathbf{P} \times \mathbf{Q})$$

Where:

Z – significance level of the study = 95% (1.96);
P – prevalence of the event = 50% were used, which maximizes the sample size when the prevalence is not known;
Q – complementary to prevalence (1-P);
N – total population = estimated older adult in the area covered by the 17 FHS teams;
E – sampling error = 6%.
Applying the formula with the parameters described above, we obtained n = 254.

The selection of participants occurred by team: the n was divided by the 17 participating teams (254/17 = 14.9), obtaining 15 older adults per team. This amount was further divided by the number of micro areas of each team. The literate older adults of each micro area were selected from the register of Community Health Workers (CHW), who provided a list with their names and addresses. From the lists, home visits were made to the number of older adults planned for each micro area. As the number previously specified for that micro area was filled, data collections were completed at that location. A home visit was carried out to collect data on 264 older adults because more than one elderly person lived in some houses.

Study protocol

For data collection, we used an instrument of sociodemographic and health characterization, and another one that assessed the FHL. The instrument used to verify the degree of FHL was a version translated and adapted to the Brazilian context[16] of the B-TOFHLA (Brief Test of Functional Health Literacy in Adults). This instrument presents a numbering test, which comprises four cards, and a reading comprehension test, consisting of two health-related excerpts, with a total of 36 items (blank spaces). The score for reading comprehension texts is two points for each blank space correctly filled, adding 72 points in total. In numerical items, seven points are counted for each correct answer, which total 28 points. The total score of the test is 100 points. Individuals scoring between zero and 53 points have inadequate FHL; between 54 and 66 points, marginal FHL; and between 67 and 100 points, adequate FHL[15,17].

A pilot test was carried out with five older adults outside the FHS coverage area. The average time of the instrument's application was 20 minutes and there was no need for changes in the instruments. The data obtained were not used.

Data collection occurred from July to December 2017, by the master's students and scientific initiation fellows involved in the macroproject who were trained in June 2017.

The objectives, risks and benefits were explained. After accepting to participate, the older adult signed or placed their fingerprint in the Informed Consent Form (ICF), in two copies.

Older adult were identified in the FHS teams from the CHW records, which indicated the participants of each micro area who were literate and took the collection team to their homes. Following the list of CHWs, if the older adult was not at home, or was not interested in participating in the study, the next person on the list was visited. The lists were organized by addresses.

Data analysis and statistics

For quantitative analysis, we created a database by digitizing the results using the Statistical Package for the Social Sciences (SPSS) version 20.0 software. The following analyzes were performed: descriptive statistics, with description of absolute frequency and relative frequency for categorical variables, and the use of central tendency measures (average) and dispersion measures (standard deviation) for numerical variables; an inferential statistical analysis, in which the ANOVA test was used to verify the difference in the average of the FHL variable for the categorical variables. The significance level of $p < 0.05$ was used.

The variables used in the study were selected from what the national and international literature[5-9,16] present as factors possibly associated with the FHL: sociodemographic characteristics (gender, marital status, education, paid job, skin color and income), health characteristics and habits (hospitalization, help with medication, help with activities of daily living, physical activity, specific diet for hypertension and participation in groups), information sources used to obtain health information (radio, television, telephone, internet and health unit) and professionals who provided health guidance (physician, nurse, nursing technician, community health worker and none).

RESULTS

A total of 264 older adult participated in the study. Among them, 25% (66) had adequate functional health literacy, 15.5% (41) marginal and 59.5% (157) inadequate.

Most of the study participants were female, living with a partner, with more than four years of study, had no paid job, they were white, with an income greater than a minimum wage. There was a statistically significant difference in FHL averages for education and income, so that older adults with 1 to 4 years of study had lower averages in the FHL scores than those with more than 4 years of study (p<0.001), and older adults with an income below 1 minimum wage had lower averages in the FHL scores than those with an income above 1 minimum wage (p=0.004).

Older adult who reported not having any hospitalization in the last year had higher scores on the FHL (table 2) than those who did, this result is statistically significant (p=0.036).

Among the means of communication used to obtain health information, the internet (p=0.047) had a statistically significant association with the FHL, with the highest average among those individuals who used it. In addition, receiving information at the health center can favor a greater FHL (table 3). However, there was no statistically significant association.

Older adult who received some kind of health guidance, whether from a physician, nurse, nursing technician or CHW, had higher scores in the FHL. On the other hand, those who reported not receiving any type of guidance had a lower score on the FHL (table 4). Thus, it is clear that receiving guidance, in general, increases the FHL, although there was no statistically significant association in the tests.

DISCUSSION

The sociodemographic characteristics found in this study, such as the predominance of females, living with a partner, having more than four

Table 1 - Distribution of older adult with hypertension according to sociodemographic characteristics and Functional Health Literacy average, Rio Grande do Sul, Brazil, 2017

Variables	n(%)	Average of Functional Health Literacy and standard deviation (X̄ ±SD)	*F/t* value	*p* value*
Gender			0,061	0,805
Female	188(71)	53,6±21,5		
Male	76(29)	48,7 ±21,0		
Marital status			0,672	0,413
Without a partner	123(47)	51,5±21,9		
With a partner	141(53)	52,8±21,1		
Education			37,970	**<0,001****
1 to 4 years of study	125(47)	43,2±14,9		
More than 4 years of study	139(53)	60,3±23,2		
Activity			0,488	0,485
Have a paid job	64(24)	57,1±22,3		
Does not have a paid job	200(76)	50,6±21,0		
Color			1,706	0,193
White	172(65)	53,3±21,8		
Not white	92(35)	50,1±20,7		
Income ***			8,601	0,004**
≥1 minimum wage	96(36)	49,4±18,8		
<1 minimum wage	167(63)	53,7±22,8		
Did not answer	1(1)			

*Note: *ANOVA test. ** Value with statistical significance. ***Minimum wage: R$ 937,00.*

Table 2 - Distribution of older adult with hypertension according to health characteristics and habits and Functional Health Literacy average, Rio Grande do Sul, Brazil, 2017

Variables	n(%)	Average of Functional Health Literacy and standard deviation (X̄ ±SD)	*F/t* value	*p* value*
Hospitalization			4,434	0,036**
Yes	32(12)	43,2±18,1		
No	232(88)	53,4±21,6		
Help with medication			0,103	0,748
Yes	38(14)	46,1±20,7		
No	226(86)	53,2±21,5		
Help with activities of daily living			1,137	0,287
Yes	54(20)	48,6±20,8		
No	210(80)	53,1±21,6		
Physical activity			0,321	0,571
Yes	95(36)	54,6±21,8		
No	169(64)	50,8±21,2		
Specific diet for Hypertension			0,616	0,433
Yes	117(44)	50,9±22,5		
No	147(56)	53,3±20,6		
Participation in groups			1,664	0,198
Yes	74(28)	54,3±22,7		
No	190(72)	51,4±20,9		

*Note: * ANOVA test. ** Value with statistical significance.*

Table 3 - Distribution of older adults with l hypertension according to information sources used to obtain health information and Functional Health Literacy average, Rio Grande do Sul, Brazil, 2017

Variables	n(%)	Average of Functional Health Literacy and standard deviation (X̄ ±SD)	*F/t* value	*p* value*
Radio			0,965	0,327
Yes	24(9)	48,1±20,3		
No	240(91)	52,6±21,6		
Television			0,554	0,457
Yes	108(41)	49,7±21,0		
No	156(59)	53,9±21,6		
Internet			3,981	0,047**
Yes	47(18)	68,6±23,4		
No	217(82)	48,6±19,3		
Telephone			0,853	0,357
Yes	24(9)	47,5±19,6		
No	240(91)	52,7±21,6		
Health center			0,037	0,848
Yes	22(8)	55,3±22,7		
No	242(92)	51,9±21,4		

*Note: * ANOVA test. ** Value with statistical significance.*

Table 4 - Distribution of older adults with hypertension according to professionals who provided guidance on health and Functional Health Literacy average, Rio Grande do Sul, Brazil, 2017

Variables	n(%)	Average of Functional Health Literacy and standard deviation ($\bar{X}$ ±SD)	*F/t* value	*p* value*
Physician			3,460	0,064
Yes	187(71)	54,0±22,0		
No	77(29)	47,8±19,5		
Nurse			0,268	0,605
Yes	57(22)	53,3±20,3		
No	207(78)	51,9±21,8		
Nursing technician			0,000	0,985
Yes	26(10)	59,1±21,8		
No	238(90)	51,4±21,3		
Community health worker			0,150	0,699
Yes	97(37)	54,8±20,6		
No	167(63)	50,7±21,9		
None			2,208	0,139
Yes	27(10)	43,7±19,2		
No	237(90)	53,2±21,5		

*Note: * ANOVA test.*

years of study, not having a paid job, being white and having an income higher than a minimum wage, were similar to other studies who assessed the FHL[9,21]. In addition, corroborating the research findings, studies that assessed the FHL of people with hypertension also found inadequate or marginal FHL in most investigated participants, as in a study conducted nationwide, in the city of Picos-PI, and internationally, in Isfahan Province, Iran[9-10].

Education was shown to be linked to FHL, so that older adult with up to 4 years of study had lower averages in the FHL score than those who studied more than 4 years. This association can be justified, since the FHL is closely related to the skills that are worked in the school environment, such as reading, interpretation and calculations[14]. Thus, when there is a deficit in these skills, the older adult with hypertension may have difficulty in understanding their own disease, drug therapy and the care that is necessary to minimize or avoid problems resulting from this condition. In addition, when the variable is associated with individuals who have NCDs, the result is a higher prevalence of non-performance of their activities due to health reasons and a greater number of hospitalizations[22].

Older adults with an income of up to one minimum wage had lower averages in the FHL score than those with an income greater than one minimum wage. This data is justified by the socioeconomic condition, which can influence access to services and health information, so that individuals who have better conditions may find it easier to obtain health care than poorer individuals[23]. In addition, socioeconomic issues may also reflect adherence to drug therapy for older adults with hypertension, since low family income can make access to treatment and purchase of drugs difficult[24]. Thus, poverty and social inequalities also favor the consumption of a monotonous diet, low in complex carbohydrates and rich in simple sugars and fats, which, when associated with the hypertension, can compromise quality of life, consequently, favor a higher risk of morbimortality, mainly caused by cardiovascular diseases[25].

In addition, older adults who had hospitalization in the last 12 months had a lower average of FHL than those who did not have hospitalization. Difficulties in understanding health information for the control of hypertension can have repercussions on low adherence to treatment and the adoption of an inappropriate lifestyle for the health condition, resulting in constant hospitalizations[26]. Therefore, it is extremely important that health professionals in primary care, based on the assessment of FHL, formulate self-care strategies that focus on the characteristics and particularities of each older adult, to minimize or exclude possible diseases that compromise active and participative aging.

Older adult who needed help with medication and to perform Activities of Daily Living (ADL), did not practice physical activity and who followed some diet had lower averages in the FHL score. This result may be related to the complexity of the therapy for hypertension and to the decrease in cognitive and functional capacities, resulting from the aging process, also being considered important risk factors for low adherence to health treatments[27]. Thus, a study carried out with Americans with an average age of 63 years old showed that having a limited and marginal FHL makes them more likely to have a worse physical condition and, consequently, to experience the effects of aging more quickly[28]. Physiological changes, typical of the aging process, and NCDs have been characterized as the main causes of functional disabilities in the older adult[29-30].

In Brazil, the National Health Policy for Older adult sets the goal of comprehensive health care for the aged, considering the condition of functionality as an important health indicator for this population[31]. Primary care, seen as the preferred access point to health services, must be prepared to provide care to this population, taking into account different functionality profiles[32]. Thus, for the organization and planning of health care for the older adult, knowing the FHL is essential, as it may guide the development of actions aimed at improving or maintaining the functionality of these individuals.

Thus, another data related to the FHL is the appointment in the center, so that individuals who have a greater number of consultations have lower averages in FHL than those who do not visit. This result may be related to the fact that those who most seek services may be those people who have greater complications resulting from their health condition, due to the difficulty in understanding the guidelines and information provided by professionals, reflecting on the management of their health problems. Thus, a study that analyzed the National Health Survey (PNS), developed by the Brazilian Institute of Geography and Statistics (IBGE) in partnership with the Ministry of Health, found that individuals with NCDs, mostly older adults, use the health service more, considering the following motivating factors for this search: the need felt by the users, who has prior knowledge of their illness and health condition; routine consultations essential for the assessment and maintenance of positive outcomes; and the highest number of comorbidities[22].

Older adults who participated in groups developed in the health center had higher averages in the FHL score than those

who did not participate. The groups in primary care are important sources of information on health, since, through collective practice, it allows problematizing and discussing, together with trained professionals, health issues, care and diseases[33]. In addition, working in groups makes it possible to expand the bond between the team and the older adult, being a complementary space for individual consultation, exchange of information, offering guidance and health education[15].

Older adults who used the internet as a source of health information had higher averages in FHL than those who did not use it. This tool has become very important for the dissemination of knowledge in the health area, with Brazil as the fifth country in the search on the internet for guidance, such as self-medication and diagnosis[34]. Instantly and simply, it allows exchanging information among individuals affected by the same disease, increasing confidence and understanding about health care[35]. Thus, it is important to promote the digital inclusion of older adult who still do not know or are unable to access the internet, so that they can take advantage of the benefits of using this technology to search for health information.

The health unit is also an important source of information, and the older adult who used it had higher averages in FHL than those who did not use it. This result is justified, as it is in the environment that professionals carry out different health education strategies, through consultations, groups and waiting rooms, which aim to identify health and disease situations, contributing to the promotion and recovery of the population health[36]. Regarding the older adults, educational activities and guidelines should stimulate the search for autonomy and independence within their social context, so that they can remain functionally active, even with a NCD, such as hypertension[36].

It is also noticed, regardless of the professional cited as a source of health guidance, that those older adults who reported receiving some type of guidance had higher scores in FHL than those who did not receive it, demonstrating the importance of providing guidance. Thus, even though professionals may use different methods, it is necessary that they are not limited to the transmission of knowledge, but that they also promote the active participation of the community, social inclusion and the constant conceptual remodeling regarding the habits that compromise the health and quality of life of the population[37].

A study carried out in Picos-PI found that people with hypertension who had marginal/inadequate FHL had a higher average age than those with adequate FHL[9]. Regarding the older adults, it is important for the professionals to know about the peculiarities of the aging process, its impact on old age, in addition to being able to guide older adults and their relatives in care, aiming at maintaining health and improving well-being from that population.

Limitations of the study

The use of a convenience sample is a limitation and does not allow the generalization of results, considering that no randomization was made, although home visits were made following the list of addresses of the CHW. However, there was no intentional selection of participants.

Contributions to the area of nursing, health or public policy

Knowing the FHL of older adults with hypertension and its associated factors contributes to the area of nursing/health, as it provides subsidies for planning health education strategies that actually meet their health needs. Thus, the study aimed to assess the association of sociodemographic and health variables, in addition to sources and means of communication used to obtain health information from the FHL. The study can still contribute to public health in general, as hypertension is one of the diseases that most affect the older adults' population. Thus, the assessment of the levels of FHL and its associated factors can assist in the development of actions aimed at care and involving the older adult, their families and caregivers, professionals and the health system. Thus, the results of this study can assist in the development of strategies that increase the FHL and help the older adult adhering to treatment and preventing complications.

CONCLUSION

Of the older adults with hypertension participating in the study, 25% (66) had adequate literacy, 15.5% (41) marginal literacy and 59.5% (157) inadequate literacy. The variables that showed a statistically significant association with the averages of FHL were education, income, hospitalization and the use of internet as a source of information.

Older adult who needed help to use medication and perform daily activities, did not practice physical activity or who needed to follow a specific diet for hypertension had lower averages in FHL. Although these results have not shown a statistically significant association, they are clinically important in the older adult population.

Older adults who participated in groups at the Family Health Unit and who received health guidance from a professional had higher averages in FHL, which refers to the importance of educational guidelines and activities, even if these variables have not shown a significant statistical association.

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