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Assessment of Treatment for Hypertension in Primary Care

ORIGINAL

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Abstract

Background: Because hypertension is a multifactorial clinical condition, primary care in this context consists in strategies for detecting and controlling the disease. Programs emphasizing this level of care incentive evaluative research as fundamental to generate mechanisms for quality assessment and control, as well as to provide information on the functioning and effectiveness of the health system. The present study aimed to evaluate the quality of health care provided for hypertensive users in primary health care.

Methods and Findings: This is an evaluative research conducted by triangulation of methods in which the quantitative and qualitative approaches were simultaneously used through observation, application of questionnaires, interviews and focus group data including managers, workers and users of a primary health care unit. The study showed that the health service has fulfilled its role of welcoming users through multidisciplinary teams as a gateway to the public system. However, the link between the health team and the community has been gradually undermined by the implementation of spontaneous demand with risk classification, compromising the continuity of treatment for hypertension.

Conclusions: Multidisciplinary team and empowerment of individuals are fundamental for the qualification of care. However, the care provided for hypertensive users in primary care has in most cases been fragmented after the implementation of the system of free access with risk classification. This fact points to the need to adapt the care needs of hypertensive users to the new health care model.

Keywords
Job Satisfaction; Perioperative Nursing; Quality of Life.

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Introduction

Changes in life habits are of fundamental importance for the therapeutic process and prevention of Systemic Arterial Hypertension (SAH). Due to the chronicity and multifactorial nature of this disease, adequate and continuous treatment is necessary for controlling blood pressure levels and reducing the incidence of cardiovascular and neurological complications [1]. These measures may ultimately contribute to the improvement of the quality of life of hypertensive individuals.

Thus, the implementation of health care models incorporating individual and collective strategies for blood pressure control, disease prevention and health promotion is important. Such strategies are fundamental aspects and the main objective of primary care.

In this context, primary care stands out as playing an important role in the strategies for hypertension control, from the clinical diagnosis and consequent therapy to the exercise of an individual-centered multidisciplinary practice.

In Brazil, the Ministry of Health has developed health policies geared at controlling hypertension in the primary care service. This care level has the objective of organizing the hypertension care line in the country, assisting the process of continuing education of primary health care professionals and supporting the implementation of local protocols to organize the care to users with chronic illnesses [2]. Furthermore, one of the main current guidelines of primary care is to conduct public management based on induction, monitoring and evaluation of processes and measurable results, thus guaranteeing access and quality of health care for the entire population [3]. Such investments in public health policies in Brazil aim to strengthen primary care services and the Family Health Strategy (FHS), and reveal the need for research in this level of health care.

In this context, evaluative research may contribute to this care model by generating mechanisms for quality assessment and control, as well as by providing information on the functioning and effectiveness of the health system [4].

Due to the complex nature of the Brazilian Unified Health System (SUS), the rapid development of new medical technologies and the growing expectations of the population, evaluative research emerges as a strategy to identify positive and negative issues in the health system and find suggestions to favor decision-making and, consequently, changes to improve service.

Regarding quality assessment, the adopted prerogative is that the idea of quality is present in all types of assessments, since their main objective is the establishment of a judgment, the attribution of value to something that, if positively evaluated, can be awarded as having quality [5].

The process of growth of the FHS in Brazil has prompted need for assessing the quality of care provided, since one of the main current guidelines is to conduct public management based on induction, monitoring and evaluation of processes and measurable results, guaranteeing access and quality of health care for the entire population [6]. Considering the need for research on the care for chronic diseases, especially arterial hypertension, in the primary level, this study aimed to evaluate the quality of health care provided to hypertensive users in primary health care.

Method

This is a third generation evaluative research carried out with the purpose of describing the dimensions of the evaluated object for later determination of its value and of the relevance of the results [7] through the triangulation of methods [8].

According to the evaluation by triangulation of methods, a team formed by professionals from several areas who seek to work cooperatively is necessary for the evaluation. This multidisciplinarity can deepen the professionals' reflections about the

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Vol. 10 No. 109
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object studied and lead them to understand it in its multiple dimensions [8]. Thus, health unit managers (coordinator, deputy coordinator and administrative assistant), health care workers (physicians, nurses, dentists, pharmacists, nursing technicians, oral health technicians, laboratory technicians, community health workers and receptionists) and users of the unit were invited to participate in the study in order to seize several points of view that may complement each other in the discussion of the object studied.

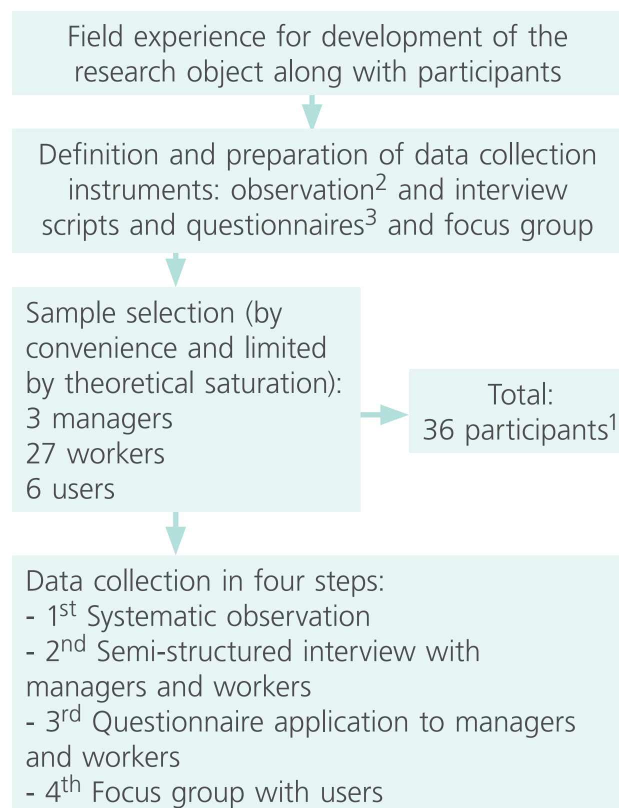
Data collection took place in a Primary Health Care Unit (PHCU) belonging to the 4th regional secretariat of the city of Fortaleza, Ceará, in the period between July and November 2015. This health unit was chosen because it is a reference institution where teaching, research and outreach activities linked to the State University of Ceará are carried out.

The study was developed according to the steps described in the figure below, according to the proposed method [8] **(Figure 1)**

Data obtained from the systematic observation were transcribed and stored in a field diary.

The items of the questionnaire were organized and tabulated in the IBM Software-Statistical Package for Social Sciences (IBM-SPSS®) version 20.0. For quantitative analysis, the Average Ranking (AR) [9] was calculated to the Likert-type scale items. In this model, a value from 1 to 5 is assigned to each answer and the weighted average of all answers make up the score of the item. The agreement or disagreement of the evaluated statements was evaluated by obtaining the AR of the score attributed to the answers, relating to the frequency of the answers of respondents. Responses corresponding to values below 3 were considered as disagreement; above 3, as agreement; and the value of 3 was considered "indifferent". The closer to 5 the AR was, the better was the view of participants about the care provided to hypertensive user within the health unit, and the closer to 1, the worse was their perception of care.

Figure 1: Description of the study steps. Fortaleza-CE, Brazil, 2016



[1]: Managers and workers acting in the PHCU for a period of more than six months and users receiving care for SAH on the days of data collection were included in the sample. Managers and workers absent from the service due to vacation or sick leave were excluded.
[2]: Observation took place throughout the period of data collection aiming to complement the information collected by the other instruments. Its script was prepared by the author taking the objective of the study as basis and was developed in a systematic, structured, open and non-participant way.
[3]: The questionnaires and interview scripts were prepared by the author taking the objective of the study as basis.

The data obtained in the interviews and focus groups were qualitatively analyzed by following the steps of thematic content analysis [10]. Following the triangulation of methods [8], in a first analytical moment, a phenomenal and technical valorization of primary (quantitative and qualitative) data was performed to triangulate them. After elaboration of categories, these recommendations were followed to analyze data collected for development of the categories in this study in order to interrelate it.

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2017
Vol. 10 No. 109
doi: 10.3823/2379

The study was approved by the Research Ethics Committee of the State University of Ceará under Opinion nº 1,068,382 and respected the ethical and legal precepts of the Resolution 466 of the National Health Council [11].

In order to preserve the anonymity of participants, presentation of results identify managers by the letter "M", health workers by "W" and users by "U" followed by randomly assigned numbers.

Results

Systematic observation was developed during approximately 40 hours along in the first month of collection and informally throughout the period of interviews, questionnaires and focus group. The script addressed the following aspects of interest for the study objective: health unit structure, service flow of hypertensive users, composition and work of the multidisciplinary team, access, bond and hosting of users.

Service flow was the most evident aspect raised in the systematic observation. It was noticeable that users come from different levels of health care, such as emergency care units, hospitals and specialized centers. This highlights the role of hosting users. Although free access allows for the provision of care to users from any territory beyond the one covered by the unit leading to diminished bond with user of the latter, the primary care duty is to welcome all users, with mechanisms to ensure that the health unit may receive and listen to all who seek assistance, with a universal and non-discriminatory attitude [2].

Regarding the participation through questionnaires and interviews, all managers and workers in the study sample answered the questionnaire, but only 16 were able to attend the interview.

The subjects covered by the questionnaires, as described in the table below aimed to lead to the understanding of the opinions of managers and health workers o. the quality of the care provided by the multidisciplinary teams at that PHCU. This information would be complemented by data surveyed in the interviews. The calculation of the degree of agreement (Average Ranking-AR) of participants with the statements proposed in the questionnaires resulted in the following averages for the addressed subjects.

Table 1. Agreement of managers and health workers with statements regarding quality of care based on average ranking. Fortaleza-CE, Brazil, 2015.

	AR	Standard Deviation
The PHCU structure provides quality	3.90	1.185
The PHCU service flow provides quality	3.20	1.186
The number of professionals in the PHCU provides quality	3.77	1.104
The care provided by the PHCU is qualified	4.27	0.785
There is training on quality in the PHCU	3.97	0.890
Users are satisfied with the PHCU service	4.27	0.828

By analyzing the AR values in **Table 1**, it was evident that managers and workers regard the health care provided by the PHCU as qualified, and the care they provide to hypertensive users as satisfactory.

Based on the answers given in the questionnaire, interviews were carried out individually with workers and managers of the unit in order to understand the object of the study.

The last step of data collection was the realization of a focus group with hypertensive users who had been diagnosed with the disease for more than one year, assisted in the PHCU studied for a period of time considered enough for them to evaluate the functioning of the unit and the care provided by workers (a period of time longer than 6 months).

The reasons that led users to seek care on the day of the focus group were diverse, which contri-

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buted to gather different opinions about the service provided in the PHCU. From then on, the reality of experienced by users in the service became clear, and the satisfaction with the care they received based on their expectations when seeking the service could be identified.

The thematic categories were created from empirical data according to the results obtained through the systematic observation, questionnaires, interviews and focus group. After the units of meaning were pooled following the transcription and reading of the interviews and the focus group, the categories were defined: "Inclusion of hosting in the spontaneous demand and impairment of the bond with the health team", "The multidisciplinary team as a provider of qualified care for hypertension" and "Empowerment of hypertensive users for the qualification of care".

Discussion

The observation, questionnaires, interviews and the focus group were analyzed altogether as a way of understanding the object of study from the multiple perspectives of participants.

Inclusion of the hosting in the spontaneous demand and impairment of the bond with the health team

Primary care represents a set of health actions in individual and collective contexts geared at promotion, protection and recovery of health. Its objective is to develop comprehensive care [2], and this should impact on the health and autonomy of people and on the health determinants and conditionings of the communities. Therefore, this level of care should be the first contact and the preferred gateway of users to the health care network.

The observations carried out in this study showed that the PHCU fulfills its role of receiving all users through the service of hosting in spontaneous demand and that assistance takes place orderly, by risk classification to meet the spontaneous demand [12]. In this system, users are assisted according to the severity of their case.

In this way, it was observed that the health care provided to hypertensive patients is structured and standardized in primary care. However, it was also observed that the spontaneous demand service with risk classification has been developed as an emergency service within primary care, giving priority to urgent users. This replaces the system of appointments with the team to whom users are linked by territory.

The existence of immediate care to spontaneous demand has impaired the establishment of bond proposed by primary care. Such bond is crucial for the construction of affective and trustful relations between users and health workers, where management of care of users is carried out by the teams and, this way, deepening of the process of co-responsibility for health is possible, building up a strong therapeutic potential over time.

Material and human resources available in the service, as well as the organizational structure itself, were evaluated in topics concerning the structure of the health unit in the questionnaires. When participants agreed with the statement regarding the structure, they affirmed that both, the physical structure of the recently reformed PHCU and the number of professionals that make up the human resources of the PHCU are paramount for the development of a qualified care.

The analysis of the questionnaires indicated that the service flow was understood as what is actually being done in terms of handling the problems presented by users. Regarding the relevance that the flow has as a quality contributor, the participants also agreed. However, this aspect had the lowest average of statements (AR = 3.20) tending to neutrality. This demonstrates that the recent change in the flow of users within the PHCU, that is, the inclusion of hosting in spontaneous demand of all users who seek the service from the year 2011 onwards

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[12], has caused negative impacts on the continuity of care provided for hypertensive users, according to the workers.

Based on the problematization of the need for bonding and user empowerment in order to seek adherence to treatment of hypertension the persistence of a strong influence of the biomedical model, focused on the use of medications in the routine of users within the health unit, was also detected in the interviews and in the focus group.

When hypertensive users were invited to give their opinion about the quality of the PHCU and the satisfaction with the health care they received, they said:

> *Quality, in this case, means constant provision of medication [...] it has been more than six months that I come here and there is no medication [...] it is always lacking.*
>
> U6.

> *The pharmacy sector, now lacks a lot of medicines [...] I came from the pharmacy today and I did not receive my medication.*
>
> U3.

Hypertension treatment involves two therapeutic approaches: non-pharmacological treatment based on lifestyle modifications (weight loss, practice of physical activities, healthy eating, reduction of alcohol consumption and smoking) and pharmacological treatment. However, in the case of the participating users, the presence of continuous prescription of drugs has often been a synonymous of quality of care, which is, therefore, the main and sometimes the only way of adhering to treatment.

The intake of drugs is a confirmedly fundamental strategy for treatment, since this practice exerts a fast and effective control over blood pressure levels. However, it cannot be adopted by the user as the only treatment route since there is evidence that users tend to discontinue treatment when they see their blood pressure levels controlled, because they do not associate the effect of the continuous treatment with the maintenance of blood pressure levels [13].

> *Some patients are really not worried about attending the appointment; they only want to get a new prescription, and thus they are more complicated patients for the team to analyze.*
>
> M2.

> *What often happens is that they (users) are only interested in the prescription; they do not even want to talk to the physician or the nurse. We often try to find out how they are taking care of themselves, but they come with the goal set on the prescription, which makes everything more complicated, since we cannot pass all the guidelines.*
>
> W7.

The association between non-pharmacological measures and treatment with antihypertensive drugs is fundamental for controlling blood pressure and the associated risks. Differently from what was observed in the speeches, non-adherence to treatment should not only be related to taking or not taking medication, but should be assumed as a reality of multiple dimensions, involving the maintenance of drug treatment and the change and continuity of a healthy lifestyle.

The speeches highlight that the "medicalization" of care provided to hypertensive users prevails over the care centered in the prevention and promotion of health. According to the reports regarding the situations in which users seek care in the PHCU, interviewees emphasized that, despite the existence of hypertensive care programs advocated by the MoH, acquisition of medications is still left in the hands of only one professional of the team.

In this sense, two directions for the problem of low adherence are possible: a) the program has

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2017
Vol. 10 No. 109
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not been able to work with health promotion and prevention; B) the population cannot adhere to the program proposed. The concomitant existence of the two situations is also possible because, the community work shows that changing habits and behaviors is difficult within short times [14].

The multidisciplinary view along with the work developed along with users, families and communities enable prioritizing the needs of clients and not only the therapeutic demands. This demonstrates the importance of the health team's performance and commitment as educators, which has been little understood by users and the by workers themselves.

The multidisciplinary team as a provider of qualified care for hypertension

With regard to the work of multidisciplinary teams, the observation identified projects with typically reduced cooperation between physicians and nurses, compromising the comprehensive assistance to users. User groups, including hypertensive groups, have been suspended for about one year due to lack of available professionals and poor compliance of users. This fact is uncoupled with the diversity and complexity of situations with which primary care deals. Comprehensive and resolute care cannot happen without a larger potential of analysis and intervention before the demands. This requires the presence of professionals with different backgrounds and a high degree of coordination within team members, assuming that the work process passes from a professional-procedure centered model to user centered model.

As for the number of professionals in the unit, the questionnaire showed that participants agreed that the existence of complete teams favors the quality of care. When they affirm that the number of professionals reflects in quality, it is also believed that multidisciplinary work is inserted in this context. This is a positive aspect, because, with the possibility of experiencing collective work in an interdisciplinary team, workers will be able to act within the new healthcare model proposed by primary care.

In this context of transformation of the SUS, the role of health workers has gone from providers of actions for healing and rehabilitation to executors of the new health policy. This requires that health care adequate to SUS principles, overcoming the individual and clinical scope and practicing a collective work process.

The theme was also recurrent in the interviewees' speeches when they were asked about what represent a qualified care. They referred to the construction of a multidisciplinary practice, based on teamwork with definition of the roles and duties of each professional, motivating users and the community to adopt effective and permanent antihypertensive attitudes.

In the programs, the hypertensive patient receives specific care [...] if the team assisting this patient is complete indeed, his evolution in the treatment will be properly followed-up [...] my role as manager is to guarantee that there always be professionals available to assist these patients, and that they work together. Our duty is always to make professionals available, and to bring patients into the health units.

M2.

The team must have good interpersonal relationships, that is, physicians, nurses and dentists, facilitating communication and making it possible to ask questions and talk about cases, about the conducts adopted.

W1.

Quality includes from the moment the patient enters the unit, goes through the reception with weight verification until the patient is assisted... all professionals are important to produce quality.

W2/W3.

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Based on these statements, it is important to recognize that the FHS should focus not only on sick users, but on their families, their environment and their community. The multidisciplinary team must act beyond curative practices and must provide universal, equitable and comprehensive care. Especially with respect to the SAH control program, as described in the category above, educational actions are fundamental for the treatment so that changes may occur in lifestyle along with medication administration.

A multidisciplinary approach to hypertension care should be encouraged and the performance of different professionals should be complementary, increasing the possibility of successful antihypertensive treatment, both pharmacological and non-pharmacological. In the view of managers and workers, as described in the statements below, the multidisciplinary work also provides an approximation and bond with the user, the family and the community seeking care.

I believe that the professional-patient relationship must always be narrowed, breaking this barrier, but this is one of the primary care philosophies, which has this function as permanent and this has evolved.

W9.

(Quality occurs) through listening, investigating the family, because very often, for example, an elderly comes without the family and we realize that he is not taking the right medication. So I always try to find out what is the family history of this patient, really, so that I can help him in his treatment, especially in the case of the elderly.

W11.

Quality means to have enough time for each patient; with educational activities associated.

W12.

The respondents' speeches denote that educational actions carried out in the services contribute for the individual to gain autonomy and to qualify their way of conducting life. This points to the need to professionals place themselves at the same level of users, thus avoiding hierarchical relationships but valuing integrative practices and popular knowledge.

In this sense, it is important to highlight that, for the development of user-centered multidisciplinary practices, the political, organizational and technical-care dimensions must also be taken into account. The political dimension refers to the mechanisms for conducting the reorganization of services; the organizational dimension refers to the relationship between the service units; and the technical-assistance refers to dimension that includes the relations established between work subjects and objects [15].

Thus, the health education process requires the commitment of a multidisciplinary team. Continuing education of the team must always be on the agenda in the aiming at raising awareness of the population to change their habits of life. Furthermore, the interaction between the different actors of care is crucial, including the collective planning of actions, more critical monitoring of the health situation of the population and the incentive to involve families and the different social segments that are directly or indirectly linked to the treatment of SAH [16].

When confronting the opinions of managers and workers with those of users with SAH who seek the service through the focus group, it was noticeable that, in the view of users, the existence of a humanized health team is also essential for the qualification of care.

(I am satisfied) with the care provided by the doctor, yes [...] with the professionals I am satisfied too.

U3.

In this context, it is imperative that users may have their demands met by the workers during the provision of care. This can trigger multiple ways of solving the problem presented, and from then on, building ways to take care of their health and to prevent hypertension-related diseases will be possible.

Empowerment of hypertensive users for the qualification of care

This category arose from the findings that hypertension is a chronic multifactorial disease and its treatment may control and prevent complications, provided users are assisted with hosting and bond and patients follow the technical guidelines given by professionals.

Regarding the qualification of the care given to hypertensive users in primary care, the average of agreement with this item of the questionnaire indicates that managers and workers believe they provide a qualified care, interacting with users and with the community, according to the SUS guidelines. They also believe in the health service's ability to solve most of the problems presented by patients.

Regarding the users' satisfaction with the care received in the PHCU, which is a fundamental aspect in this quality assessment, the AR 4.27 indicates that workers and managers believe that users feel satisfied. Considering the solving capacity of the PHCU, managers and workers believe they can solve or alleviate the complaints that motivate users to seek the health unit. They also propose changes related to the health status, knowledge and behaviors of hypertensive users.

In this context, besides the statements of the participants, the fundamental importance of treatment adherence for the controlling blood pressure levels was evident. Hypertension cannot be seen as a disease that needs to be treated exclusively in the health service, but rather as a disease that needs a care where patient and service play their roles, at the level of their competencies. It is opportune that patients understand that the conception of health comes from personal experiences and is narrowed by beliefs, values and feelings; these directly influence the way people develop coping and treat the disease [17].

The participation of users in the antihypertensive treatment was emphasized in the speeches of health workers. It was noticed that the interviewees feel daily "challenged" by the lack of adherence and demotivation of the user before health promotion actions proposed by the service, such as educational activities.

Consultations are practically inexistent because patients are more interested in prescriptions and not in the proper consultations, ignoring the self-care.

W7.

Having a good team, making the right recommendations to guide the patient is all pointless if patients do not try to follow the treatment, do not follow the diet or do exercises, if they take medications improperly, etc. Treatment will only have quality if responsibility is shared, because the team often does its best, but the patient does not [...] the community should always demand the best from us, but they also should try to do their part [...] some actions have been suppressed lately. In the case of hypertensive patient, we could apply some actions, such as: lectures, group guidance, physical activities linked to partnerships with health units that have this space.

M2.

Shared responsibility and the strengthening of links are crucial factors for the development of users' autonomy in their treatment.

The Family Health Strategy sought to reorganize the Brazilian Health System (SUS) by abandoning the curative and hospital-centered model and replacing it by a model with emphasis on Primary

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Health Care and on the principles of territoriality and collectivity. However, despite the increased access of the hypertensive individuals to health services brought about by the FHS, low adherence to treatment still persists.

This fact can be explained by the resistance to changes in the care model and by the degree of implementation of the FHS that reflect advances in some aspects of health care, but still fall short the ideal of making the FHS a priority and central strategy at the local level. Therefore, the difficulty to incorporate the substitutive strategy persists [15].

The control of SAH has been one of the priorities of the PHC. However, educational experiences aimed at hypertensive users are still often restricted to prescribing medications, with little health education aiming health promotion and subjects' autonomy.

The assumptions of care/taking care in the process of health education are based on the idea that listening and welcoming should be valued in order to lead individual to adhere to preventive and control behaviors against health problems [18].

Hypertension is controlled with active participation of hypertensive individuals, families and by health professionals. Health education processes are needed, as well as commitment of a multidisciplinary team. This is highlighted in the following speech.

> *What makes it difficult is the information that patients have about this matter. For them to evolve in the treatment, they need to know the disease properly, to understand why they are sick, what they need to do in the short and long term; it is not that they do not have this knowledge, but it is a continuous process.*
>
> W9.

Health workers, when inserted in the dynamics of the community, can act by increase the knowledge of users about their illness and strengthen strategies for adoption healthy life habits. The approach and interaction of workers with users through the Family Health Strategy prompt their search for primary health care. Therefore, it is fundamental that the primary health service broaden its field of knowledge and responsibilities, making the actions of professionals more humane and comprehensive, innovating in the way of producing health [19].

In this context, the attitude of health workers should not be of contentment and withdrawal, if the user is not aware of the importance of promotion and prevention activities, they can be helped through health education to understand their reality, and then adhere to treatment.

Conclusions

The care given to hypertensive users in primary care has often been fragmented after the inclusion of hosting to the free demand, according to the perception of managers and workers.

In fact, the stimulus to free access and reception of spontaneous demand in the PHCU studied did not take place as recommended by the Ministry of Health, which seeks to legitimize primary care as a priority and preferential gateway for SUS, guaranteeing continuity of care to hypertensive users.

Regarding the opinions of users, an important finding of this evaluation was the devaluation of education and health promotion practices for the treatment of hypertension. It was noticeable that hosting and bond were not associated with quality of care. For this group, a qualified health service is strongly associated with medical consultations and with availability of medications in the PHCU, revealing that the "medicalization" of hypertensive care overlaps with care focused on prevention and health promotion and also that the continuity of treatment has been compromised by the low contribution of users towards non-pharmacological treatment.

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2017
Vol. 10 No. 109
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The results point to the need to adapt to the new health reality experienced by primary care in the case of treatment of hypertensive users, seeking strategies to favor the qualification of the service and the treatment of the user.

The methodology used, that is, the evaluation by triangulation of methods, proved to be a tool for understanding the PHC care practice in a comprehensive way, by crossing different data collection techniques applied with participants from different categories, with their different views and reflections.

It was, thus, possible to understand the relationships between the structure of the unit, the professional work process and its relations with the community in their social context, and the results achieved with the individuals who seek the health service, providing quality of care and user's satisfaction.

Therefore, the process of growth of the Family Health Strategy in Brazil and the incipience of research that relates the qualification of services to primary care show that other processes to evaluate the quality of the care provided are still necessary to ensure the comprehensiveness proposed by the SUS guidelines.

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