

SYSTEMIC ARTERIAL HYPERTENSION: SOCIAL REPRESENTATIONS OF PATIENTS ATTENDED AT PRIMARY CARE ABOUT THE DISEASE AND ITS TREATMENT

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Introduction: Systemic Arterial Hypertension (SAH) is considered as a very relevant public health problem, due to its high frequency in the population worldwide. Social Representations (SR) have been approached in studies aiming to understand the relationship of the cultural and psychosocial aspect with the means of coping by people with SAH, justifying and guiding their attitudes and expectations regarding their condition. **Objective:** The aim was to understand SR of patients with Systemic Arterial Hypertension in relation to the treatment, therapy compliance and risk factors for complications. **Methodological strategy:** A qualitative approach was used according to the Minayo perspective and interviews guided by a semi-structured script as research technique in a Family Health Unit in Salvador-BA. **Results:** A total of 18 key-informants ranging in age from 32 to 72 years participated in the study. In general, the users were mostly sedentary (83.4%) and were overweight or obese (44.5%). The data was organized into three phases for analysis: ordering, classification and final analysis, permitting the determination of the priori and emic. Individuals reported difficulties regarding the need for daily medication intake and the adoption of healthy lifestyle habits, suggesting differences between common sense and technical knowledge. **Final considerations:** Multiple influences were perceived of individual beliefs and from social networks on adherence to treatment. The SR of the hypertensive patients interfere directly with their perception about the disease, guiding them in their health behaviors.

Keywords: Hypertension; Social representations; Primary health care; Risk factors,

INTRODUCTION

Systemic Arterial Hypertension (SAH) is a non-communicable disease, regarded as the main risk factor for cardiovascular diseases and considered as a very relevant public health problem, due to its high frequency in the population^{1,2}. The Brazilian Institute of Geography and Statistics indicated that the prevalence of SAH in 2013 was of 21.4%, corresponding to 31.3 million people³.

Therapy compliance is of utmost importance due to the chronicity of SAH⁴. Factors such as the awareness of hypertensive patients about their condition⁵, health-disease conceptions⁶ and social networks, for instance family relationship⁷ and the health team⁶, directly influence therapy compliance. Social Representations (SR) have been approached in studies aiming to understand the relationship of the cultural and psychosocial aspect with the means of coping by people with SAH, justifying and guiding their attitudes and expectations regarding their condition⁸. These result from common knowledge and lay knowledge formed from experiences and communication processes⁷.

Representation is something complex which encompasses always an object and a subject, having in these aspects and symbolization and meaning. We created the SR in order to be able to adjust to the context in which we live, before people, objects and occurrences, in an attempt to administer and understand them⁹. Regarded as a rich and complex phenomenon, from SR it is possible to identify various elements that reflect the common sense, such as opinions, attitudes, beliefs, ideologies and values. Meanings attributed to these elements are relevant, once these will guide the subject in the approach to health, influencing directly in the treatment process and quality of life⁸.

Despite the fact that researches that approach this perspective having been published among Brazilians, emphasis is given to regional cultural issues. Thus, the literature available in this area is still incipient, which justifies new studies dedicated to understanding the process of social construction of these representations in people with hypertension. Therefore, the objective of the present study is to understand the social representations of systemic arterial hypertensive patients in relation to the

treatment, their compliance and the risk factors for diseases resulting from this pathology.

METHODOLOGICAL STRATEGY

The qualitative methodology was chosen, according to the Minayo¹⁰ perspective. In this strategy the speech of the social actor is situated in its context in order to better understand, having as a starting point the interior of the speech, and as a destination point the field of historic and totalizing specificity produced.

SAH patients being cared or looking for care at a Family Health Unit (FHU), in the city of Salvador, Bahia were invited to participate. Those present at the units during the period of data collection and who agreed to participate and sign the Informed Consent Form were included. Those who wished to interrupt the interview and not proceed with the research were excluded.

An interview guideline was prepared with the purpose of exploring the theoretical dimensions of compliance to treatment and hypertension control. The questions were related to clinical and demographic information. Other questions led the individual to report his/her knowledge about the pathology and its treatment, as well as on how they cope with the condition of being hypertensive. Data collection was performed by scholarship holders linked to the Educational Program for Health Work (PET-Saúde), performed by means of an agreement between the Ministry of Health, Universidade do Estado da Bahia and the Municipal Health Department.

Data collection was conducted, after the training of the interviewers, between August and November, 2013. All the interviews were recorded in an RC® device and then transcribed *ipsis litteris*. This method of collection from interviews is based on the ideas of Quivy & Campenhoudt¹¹, who characterized it as a rich method for data collection where there is an exchange through direct contact between the interviewer and the interviewed party, where the latter is capable of expressing experiences within his/her own frameworks. All participants were identified with fictitious names.

For data analysis, the suggestion by Minayo¹² was used, involving the organization of the data into three phases: sorting of the data, classification and final analysis. The first phase consisted of the transcription of the recordings and organization of the accounts. Data classification was performed by means of horizontal and vertical readings of the texts in an intense and repeated manner, in order to identify speech patterns of the participants for each priori analytical category. It was possible to identify relevant aspects when questionings were established from the readings, creating in this manner, connections between these aspects and permitting the determination of emic categories.

The emic categories emerged from the priori category of Health and disease conceptions. Knowledge in relation to the cause and the evolving course of the pathology, as well as the sentiments of these individuals in the face of the condition of being hypertensive. From the category Care, the categories of Prevention, Treatment compliance and its influential factors were established. From the category of Social networks emerged the discussion about the influence of interpersonal relations and of social actors perceived as support, religion and Primary Care, which can have a positive or negative influence in the lives of these individuals.

In the final analysis, connections were pursued between the speeches and the theoretical referential of the object under study. In this manner, the aim was to understand the perception of the SAH patients in relation to their knowledge about the pathology

and its treatment, as well as means of coping with the condition of being hypertensive.

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RESULTS AND DISCUSSION

Characterization of key-informants

A total of 18 individuals, here referred to as key-informants, met the criteria for inclusion and exclusion. It was observed that 77.7% of the individuals were female, 55.5% were between 32 and 59 years old and all were black or brown. With respect to formal education, 72.2% of the subjects were classified as having low level of education because they had completed all or part of elementary education and 27.8% as an average student because they had reached secondary school, having concluded. As for the marital situation, it was categorized into two strata, single, widowed, separated or divorced, meaning that they lived without a partner and those who were married or living in a stable union. The study subjects were classified as having no partners in 50% of the cases. All declared themselves religious, of which 38.9% were Catholics, 33.3% were evangelicals and the others reported practicing other religions.

Table 01. Socio-demographic characteristics of the participants of the study

Name	Age	Marital status	Race/color	Schooling	Religion
Raquel	72	Single	Brown	Illiterate/Fundamental I incomplete	Protestant
Renata	51	With partner	Black	Fundamental II complete	Other
Geovana	70	Single	Brown	Fundamental I complete	Evangelic
Wilson	61	With partner	Black	Fundamental I complete	Protestant
André	49	Single	Black	Fundamental I complete	Catholic
Suelen	64	With partner	Brown	Fundamental I complete	Catholic
Analú	45	With partner	Black	Fundamental I complete	Catholic
Arlete	58	Single	Black	Fundamental I complete	Evangelic
Milena	58	Single	Brown	Fundamental II complete	Other
Michele	65	Single	Brown	Fundamental II complete	Catholic

Table 01. Socio-demographic characteristics of the participants of the study (continuation)

Name	Age	Marital status	Race/color	Schooling	Religion
Alana	33	Single	Black	Fundamental I complete	Other
Carine	69	Single	Black	Illiterate/Fundamental I incomplete	Evangelic
Marília	35	With partner	Black	Secondary school complete	Catholic
Bruna	32	With partner	Brown	Secondary school complete	Other
Geraldo	49	With partner	Brown	Fundamental I complete	Other
Luísa	38	With partner	Black	Illiterate/Fundamental I incomplete	Catholic
Marcos	68	With partner	Black	Illiterate/Fundamental I incomplete	Catholic
Brenda	68	Single	Black	Illiterate/Fundamental I incomplete	Evangelic

Regarding the clinical variables of the hypertensive patients, the associated Diabetes Mellitus was present in a patient, who was not able to inform the type of DM and did not have a history of amputation. It was found that 83.4% of the subjects did not practice physical activity and 44.5% were obese. Regarding the health history of these patients, it was observed that 22.2% reported suspicion or history of infarction, 22.2% of strokes and 5.5% of renal disease.

Table 02. Clinical characteristics of the participants of the study

Name	Overweight or obese	Physical activities	Diabetes	Background or suspected CVA	Background or suspected infarction
Raquel	Yes	No	No	No	No
Renata	Yes	Yes	No	Yes	Yes
Geovana	Yes	No	No	No	No
Wilson	No	Yes	No	Yes	Yes
André	Yes	No	No	Yes	No
Suelen	No	No	No	No	No
Analú	Yes	No	No	Yes	Yes
Arlete	No	No	No	No	Yes
Milena	No	Yes	No	No	No
Michele	Yes	No	Yes	No	No
Alana	Yes	No	No	No	No
Carine	No	No	No	No	No
Marília	No	No	No	No	No
Bruna	No	No	No	No	No
Geraldo	Yes	No	No	No	No
Luísa	No	No	No	No	No
Marcos	No	No	No	No	No
Brenda	No	No	No	No	No

Health-disease conceptions

Concepts related to the health-disease process are analyzed in accordance with the historical, political and social context in which it is inserted, being dynamic and complex. Thus, the SR of individuals is intimately related in this process, and values and beliefs should be considered when proposing any treatment intervention and prevention or even the manner of the diagnosis itself¹².

During the interviews, when questions related to the cause of the disease were approached, divergences were observed in the discourse of the key-informants in relation to health-disease conceptions, once it is usual to associate the advent of the pathology to one sole risk factor:

"It is hereditary. Family history". (Bruna)

"[...] it was due to a fright. It was because there was a woman at the other clinic who was feeling sick, really poorly, and when I saw she had passed out, I was frightened [...] then when the doctor saw me she said "your blood pressure is high, it must have been the fright you had". (Arlete)

"[...] because some people say high blood pressure is emotional, it can only be that, because the only person with high blood pressure at home is me". (Carine)

The understanding of the subjects in relation to SAH does not contemplate the multiplicity of risk factors and is distanced from causal phenomena established by scientific knowledge. Although these people received healthcare at a FHC, there seems to be weaknesses in the health education process that could have been offered by the professionals of the health units.

The lack of technical knowledge of some hypertensive patients with respect to the chronicity of the pathology was also demonstrated in the study by Mantovani et al.², when doubts were identified in the answers of the individuals when questioned about the cure for SAH. They answered positively, but signaled that should they stop the treatment, the disease would return. Other stated that there is permanent cure after a period of treatment and the lack of signs and symptoms. The cure of the disease also appeared in the narratives of the interviewed

hypertensive subjects. It is possible to observe below the belief in recovery of good health conditions, when believing that the disease has been overcome.

"I believe that one gets better, because sometimes the person recovers, is cured, right? I was already cured and was well for some time without taking medication, then I began to take medication again because I felt ill again, then I went to the doctor. The doctor told me to take the medication again. I took the medication before sleeping. Then I got better. I went for a long period without taking medication". (Suelen)

"According to the doctor who took care of me, high pressure can be controlled. But I believe if one controls it well then one recovers and can stop taking medication". (Wilson)

It is possible to observe the lack of awareness of the chronic characteristic of SAH and the need for antihypertensive treatment for life. Individuals with this approach are more susceptible to SAH complications, once they can obtain an unsatisfactory response from the treatment or abandon it completely, requiring a greater awareness about the importance of treatment with medication. It is also possible that this belief is due to an attempt of the subject to deny a part of reality, due to a difficulty in changing lifestyle habits.

With the aim of obtaining the awareness of the SAH patients in relation to complications deriving from the pathology, Mantovani et al.² report that the interviewed patients mentioned, in their majority, Cerebrovascular Accidents (CVA) and Acute Myocardial Infarction (AMI) and association to death, but few mentioned kidney and visual complications. These findings corroborate the present study, observing in all the speeches the awareness of possible complications. In these pronouncements the informants mentioned CVA, cardiovascular complications and death. It was also possible to perceive the fear of such events by the hypertensive subjects.

"[...] people talk mostly about stroke, brain hemorrhage, right? Others have strokes, but the normal stroke. In my case it was stronger. Cerebral hemorrhage, CVA. But I hear that cerebral hemorrhage is more serious". (Wilson) "Ah, it brings death, right". (Suelen)

"It can trigger diabetes, right? Apart from the CVA one can have cardiac problems and other things". (Milena)

It was observed that the interviewees, despite having knowledge of the disease, interpreted in a confused manner information on the seriousness and magnitude of the event itself. Outcome such as death and other chronic conditions, such as DM, were also mentioned. Fear of the consequences from SAH when not controlled favors the adoption of positive behaviors in relation to treatment, and could be a factor of motivation for therapeutic compliance.

Once it is a non-communicable chronic disease, hypertension has received great attention from health professionals in the last decades¹³. Feelings and emotions stemming from the moment of the diagnosis could guide the hypertensive patient in his/her health approach basing behavior on the health condition¹⁴.

The accounts point out to varied sentiments and reactions when faced with the condition of being hypertensive. Speeches reveal sentiments of concern, fear of related diseases, conformism and acceptance. Others point out to the sentiment of outrage associated to this condition.

"My concern is because my hypertension is silent. Sometimes it is normal and then too high. So my concern is a CVA". (Marília)

"Today I am conformed, I accept well, but sometimes I get upset because of eating. You are forced not to eat some things that sometimes I would like to eat". (Bruna)

"Look...not being able to do things, to get agitated, right? The pressure goes up, that's what happens. So I cannot dance, ok? I can't have a beer, mainly that". (Luísa)

"Sometimes I get really upset, I can't stand anything. If I could I would hear anyone's voice. Sometimes I get nervous, sometimes I am normal. But there are days I don't want anyone near me". (Alana)

The need for changing lifestyles has a direct influence in the social life of the patient, and can even lead to social isolation, once individuals can avoid, for example, going to parties or meetings, in order not to eat certain food which is inadequate to their diet.

This fact could lead to loss in leisure activities and social relations, causing different sentiments when faced with this situation.

Care

Kleinman et al.¹⁵ approach healthcare in different perspectives: professional healthcare, which deals with the formal care, doctor, specialized, and informal care, which are the popular, folk care, which refers to self-care, family care, self-help groups, healers and others. It is believed that 70% to 90% of this kinds of healthcare are exclusively outside professional care¹⁵, making evident the need for greater knowledge about the nature and efficiency of therapy in these sectors of informal care.

Under the perspective of self-care, the hypertensive subjects were questioned about the forms of prevention of SAH. It was observed that on one hand, when associated to heredity, they reported that there was no means of prevention and that it would appear sometime. On the other hand, there was also the mention of inclusion of modifiable factors:

"Avoided? I don't think so. Because it is hereditary. So, when the family has it, the tendency is that everyone will. My mother and my father both have. Not diabetes, but high blood pressure". (Alana)

"I believe that the diet, remove the salt first, fat – which is what I do, I don't know....peace also, with the family, right? If we take good care we don't become [hypertensive]". (Suelen)

The multifactorial nature of SAH seems to be a factor that hinders the approximation between technical knowledge and common sense, in detriment to the understanding of its etiology. Prevention strategies should be a fundamental component of Primary Care, and should be intensified in order for the information and knowledge to reach the population in a clear manner.

The treatment for SAH has the purpose of controlling blood pressure levels and consists of pharmacological and non-pharmacological behaviors, including changes in lifestyles. In their studies, Costa e Silva et al.⁷ and Bento et al.¹⁶ indicate the dubious feeling of hypertensive people about the importance of

the treatment with medication, once individuals demonstrate awareness of the benefit of the treatment, but are not able to follow the treatment or do not want to, or ignored the consequences of not strictly doing so.

The studies mentioned above evidence that often hypertensive patients change the prescribed doses and the times of taking the medicine on their own accord, when convenient, such as, for example, increasing the dose during a hypertension crisis and discontinuing the medication in asymptomatic situations. The accounts below corroborate these findings.

“Daily. I mean, yesterday I didn’t take it. Today I took my pills. Because I take two. [...] I mean, sometimes I don’t take the medication and I don’t feel anything. I don’t take it when I feel that my heart is not beating fast, then I don’t take it. Then I think that I could continue and wouldn’t feel anything, but the doctor says that I must take it, because of my age, right? Because she says sometimes your pressure is normal, but sometimes it is altered, right? That’s what scares me”. (Raquel)

“Sometimes I feel like taking the medication. Sometimes I don’t. [...] I bought Captopril. I take it on my own will”. (Alana)

These accounts demonstrate the difficulty in relation to the need for daily intake of oral medication for a disease which is often asymptomatic, and which requires lifelong treatment. Compliance to the treatment with medication suffers intrinsic influences of the patients themselves such as their routine and their relation with the health team. The findings of this research can also be attributed to the weariness induced by the need for taking medication daily, leading the individual to avoid this situation which is a reminder of his/her condition of having a chronic disease.

Self-medication can be attributed to the swiftness and ease of buying medication without a medical prescription, at the pharmacy, demonstrating a weakness in the monitoring of these hypertensive patients. Investigations about the health condition of patients and guidance in relation to control measures of their pressure levels should be performed in such a manner that the information on the medication

treatment and of the need for this treatment reaches the individual in a clear manner.

Scientific evidence reveals that the fear of death due to SAH complications plays an important role as motivation for continuing treatment, despite forgetfulness^{7,17}, fear of addiction to the medication¹⁸, collateral effects⁵, difficulty in keeping up the correct timetable^{7,17} and of multidrug¹⁹ continue present as complicating factors. Such aspects are clearly evidenced below:

“Because I would become addicted to the medication, I think. I always come here to measure my pressure to check, and it is always normal. I will not take medication, filling myself with medication without the need”. (Luísa)

“I take a lot of medication I don’t remember the name of the others. For high cholesterol, pressure.... Today I left in a hurry because of my husband, and I didn’t take my medicine, now I am scared?”. (Luana)

A possible explanation for such behaviors could be the lack of health education groups and not systematically stimulating compliance to therapy.

It is known that treatment with medication has its effectiveness increased when associated to non-medication treatment¹. This includes general improvement of lifestyle habits, eating habits with low content of sodium, maintain adequate body weight, practicing physical activities regularly and giving up smoking and drinking. It can be observed below that this knowledge is present, although in an incipient manner.

“I used to walk and practice physical activities, and decreased the use of salt in my meals. I believe it has helped”. (Bruna)

“My blood pressure increased and I drink alcoholic beverages. I began to drink. Drink a lot on weekends and, thank God, I am trying to stop”. (Geraldo)

Treatment focused solely on medication can have a negative influence when causing a low adherence to non-medication components to the treatment, which are usually necessary for a complete perspective. This fact can be explained by the greater commodity in concentrating only on the treatment

through medication, once it requires less time when compared, for example, with physical activities. The consumption of alcoholic beverages and eating habits runs through the whole social context of the individual, which needs to be altered as from the diagnosis of SAH, and could be something more complicated to be changed.

Studies demonstrate that emotional factors such as stress and anger⁵ are perceived by people with SAH as the main reasons for triggering hypertension crisis. The interviewed parties in the present study reported that the elimination or decrease in these factors help control the blood pressure levels.

“Not worrying with many things because it is emotional, we have so much on our minds”. (Renata)

“Yes, mainly avoiding the day-to-day stress”. (Milena)

There is a tendency for overestimating the effects of stress on blood pressure and how it is valorized in the standpoint of common sense. It is also a means of attributing the fault of the increase in the blood pressure levels to others.

Within the Care context, it is observed that beliefs influence significantly and directly in the treatment. The interviewees brought with them their discourses on regional cultural practices such as the use of homemade juices or teas as a partial or total substitution to the treatment, corroborating the findings of Leão e Silva et al.¹⁹, when interviewing elderly patients with the pathology using this same practice. This can be observed almost unanimously in the discourses below.

“I cook chayote, passion fruit juice helps, watermelon, watermelon juice”. (Renata)

“Lemongrass tea, anise tea, chamomile tea. I drink tea, I am not sure why, when my pressure is high. The girls get chayote and passion fruit, make a thick tasty juice and I drink it with a pill, and my pressure improves”. (Geovana)

Medicinal plants were the first alternative for cure for primitive man and these practices have always been present in the history of mankind. Herbal medicine has evolved and the influence of plants is being studied, improved and applied throughout time²⁰.

Nevertheless, once this knowledge is maintained mainly through oral tradition, it is necessary to be careful that the treatment with medication is not neglected, once evidence on such practices is minimal. The importance of popular practices in healthcare is emphasized by Laplantine²¹, when reflecting a more comprehensive outlook on the disease, promoting an integration of somatic, psychological, social, spiritual and existential aspects.

Social networks

Social networks refer to the ensemble of beings with whom we interact regularly. These can be made up by people, services, beliefs and objects, and can also have a positive influence in the perspective of support or negative when causing damage²². Sluzki²³ addresses also the concept of social networks as relations that the subject perceives as important, with which there are traces of affinity, contributing towards self-recognition and self-image. Social networks suffer changes throughout life, according to changes and necessities occurred.

The SAH diagnosis can significantly impact the lives of people, once it is a chronic condition and requires the adoption of new living habits. Various strategies for coping are used in order to face the new condition, such as spirituality which may or may not be linked to religiousness²⁴. Spiritual support is found in the scope of social networks, being of great importance to the individuals, finding comfort and support to face the treatment.

“[...] our faith, pray, ask God, deliver in the hands of God, then we think it is solved, right? Everyone has their own faith, we are catholic, and even more so because we believe in God, and everything we ask He answers. We cannot see Him, but the Holy Spirit is among us, as is said: when there is one or two joined in His name, these shall be purified and kept”. (Raquel)

“God helps me. I alone and God. Because to go out and buy medicine, it is I. To pay the medicine, it is I. To make an appointment with the doctor, it is I. Everything I have to do! Jesus helps me, right? God helps me. No-one else does”. (Brenda)

It is possible to observe above the importance of faith, in the power of spiritual aid. It is an aspect

present in the requests for support through prayer and in transferring part of the importance of the treatment to God or a superior being. It is presumed that religion contributes also for the increase in the network by creating new relationships due to the ties among those who belong to the same religious congregation.

The Family Health Program (FHP) is highlighted as an important strategy guided, above all, towards the preservation and promotion of health, being an influential network in the compliance to treatment of the hypertensive patients through the constant monitoring of these patients. This aspect is relevant to this research, once it was carried out in a FHU with the adscript patients.

In this same perspective, the positive support of doctors from the Unit is seen as a relevant aspect in this research. The care and guidance offered by these professionals are of fundamental importance for a clearer understanding of the pathology under issue, which reflects directly in the compliance of patients. The patient-health team bond is of great importance in the sense of informing to the patients all the necessary aspects related to their pathology, aiming towards a greater adhesion of these individuals to the treatment.

“[The doctor] told me to do all these heart exams. A lot of things, to have this healthcare. She told me to walk, avoid salt, avoid fat. It is being god. I am being accompanied. I will take her the exams. She will tell me what to do. It only depends on me now”. (Geraldo)

“That’s it, she [the doctor], is treating me. She is very careful with me. I did the exams and took them to her, she showed me and explained everything and set the appointment”. (Brenda)

It can be observed, nevertheless, that other health professionals do not appear in the discourses of the interviewees. For the population when asked about the health agents, they are generally the doctors. However, it should be emphasized that a multiprofessional team is important and necessary for full adhesion to the treatment of hypertensive patients, once this team can offer a more comprehensive educational and therapeutic actions, making treatment more effective.

There were also questionings in relation to some aspects of the health service. Access to health services was reported as difficult, the lack of information about the health service, lack of medication and the delay for setting up appointments were included in the discourse of some individuals.

“I think it is good. In truth it is not good when one comes here and there is no medication, ok? ‘Ah! There isn’t any, it hasn’t arrived’. I mean, one has to go there, sometimes two or three times without getting the medicine. I myself didn’t know I could get it for free at the pharmacy. After I was up there, a lady was telling me and went there and got my medication. People should tell us about that. Oh my dear, we have to run around to get things. Here is ok because it is close. I live nearby, but have to get here early. To get a doctor’s appointment at the health center, there are long queues, one has to leave home really early to be attended, and sometimes you aren’t”. (Carine)

“Oh, it is very difficult, sometimes they tell you to come on a certain day, then you can’t get an appointment, it is complicated. We have to come here, we live near here, so this is where we have to come, right? But sometimes you come and are not attended. I have been coming since last week and haven’t been able to get an appointment. I did the exams here, but I can’t show the doctor, not today”. (Luísa)

One of the attributes of the Primary Healthcare is its accessibility, translated by the necessity of representing a doorway to the health service. In other words, all the barriers should be combated and user should feel welcome in units that receive them and offer healthcare. The difficulties in setting up appointments and the unavailability of pre-set appointments suggest the presence of organization barriers that should be countered. The statements suggest also the lack of respect and attention to the other, attribute which should be taken into consideration by those responsible for the management of the units. The longitudinality or the need for continued care and bond between the patient and the service could also be compromised, once difficulties were stated for setting-up appointments.

Still within the scope of Social Networks, Costa e Silva et al.⁷, in a study conducted only with patients of the female gender, demonstrated that the

attention and support of their children, husbands, neighbors, among others, helped them accept their condition and in coping with the pathology. This research observed deal with their treatment.

"I have a sister-in-law who helps, right? She also has blood pressure problems. We walk together, and she helps in relation to the diet". (Renata)

"My sister helps me: Look, don't eat salt, less salt. She says". (Marília)

It is important to observe that the family appears also as the causer of damages. Some informants associate the appearance of the disease to conflicts caused by relations with family members. This aspect demonstrates the multiple influences, consequences and variations of the functions of social networks.

"I had a family issue. I lost a father. I didn't lose a daughter, because my daughter left home. My daughter was in university and went to get married. She found a guy to marry and I was overwhelmed and the pressure went up and up". (Geraldo)

Sluzki²³ discoursed about the way in which social networks affect and are affected by the health condition of the individual, generating health or disease. Family is seen as a "virtuous circle" when assisting in a positive manner the health of the individual. The opposite is also true, called a "vicious circle" the situation in which the family generates the aggravation of the disease.

FINAL CONSIDERATIONS

The SR of patients with SAH interferes directly in their perception of the disease, guiding them in their health behavior. In this perspective, the diagnosis of a chronic non-communicable disease such as SAH involves the whole bio-psychosocial context of the patient, once changes in the lifestyle of the patient are necessary in order to control adequate blood pressure levels. In view of the results obtained, it is clear that the knowledge of the hypertensive subjects in relation to their pathology is modeled on hereditary influences, on the mind/body integrality, religiousness and on traditional knowledge. Such aspects will exercise a direct influence on their

treatment and compliance, once good understanding is essential to have awareness about the necessary care to control hypertension, emphasizing also that non-compliance to the correct treatment could entail complications stemming from the disease.

The present study represents a relevant source of information with respect to the perception of hypertensive people about the dimensions of their pathology, evidencing the importance of the subjectivity of the individual as decisive to their health, an instrument capable of assisting the health services to develop actions and measures, aiming for improved monitoring and accommodation of these patients, giving due importance to popular knowledge, which should be allied to the scientific knowledge. New studies should be conducted in order for the assistance to the hypertensive patients to involve matters related to social representations, as well as biomedical knowledge.

AUTHOR CONTRIBUTIONS

Fraga-Maia H participated in the conception, delineation, search and analysis of the research, interpretation of the results, writing of the scientific article and referral of the scientific article. Brito SN participated in the conception, delineation, collection of research data, interpretation of data, analysis and writing of the scientific article. Zarife AS participated in the interpretation of the results and writing of the scientific article.

COMPETING INTERESTS

No financial, legal or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

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