Original Article

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Manifestations and attitudes regarding difficulties in adhering to pharmacological treatment among elderly hypertensive patients in primary care setting

Manifestações e atitudes acerca das dificuldades de adesão ao tratamento farmacológico por idosos hipertensos sob atenção primária à saúde

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Summary4

Introduction: Systemic Arterial Hypertension is a disease with high prevalence and impact on the lives of the elderly population, emphasizing the need for constant and adequate treatment, whose impact is crucially influenced by multifactorial agents such as pharmacological adherence and rational use of medicines. **Purposes**: This study aims to understand pharmacotherapeutic non-adherence among elderly people with hypertension treated at a Unidade Básica de Saúde [Primary Healthcare Unit]. **Materials and Methods:** It is a qualitative study involving description and content analysis, conducted with 20 elderly hypertensive patients who had difficulties adhering to the proposed therapeutic plan and were registered at a Primary Healthcare Unit in the South Zone of São Paulo. Data collection took place through in-depth interviews based on a questionnaire with pre-formulated questions, from January to February 2024. Laurence Bardin's methodology was used for subsequent content analysis. **Results:** Medication adherence among hypertensive elderly people was affected by several factors, such as memory lapses, alcoholism, side effects of pharmacotherapy, polypharmacy, limited perception of the benefits of treatment, low availability of medications and low understanding of the disease itself, connected to the right to autonomy to manage one's own treatment. **Conclusion:** pharmacotherapeutic adherence is multifactorial, which highlights the relevance of care that adopts the patient's perspective as a biopsychosocial being, taking into account their individuality and particular demands, thus allowing the identification of the feelings underlying the diagnosis and treatment.

Keywords: medication adherence, primary health care, aged, hypertension; public health; chronic disease

Abstract

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Introduction

The phenomenon of globalization and the installation of urbanization in Brazil resulted in the change of important social aspects that significantly impacted the demographic and epidemiological transition of the country. Therefore, the decline in mortality from infectious and parasitic diseases from the 1940s to the present day is remarkable, with the increasing incidence of chronic non-communicable diseases over the years [1,2].

Added to this reality is the fact that Systemic Arterial Hypertension (SAH) is characterized as a very prevalent disease among what fits as cardiovascular diseases [3]. According to the Global Health Estimates, developed by the WHO, cardiovascular diseases are among the leading causes of death in the world and, in addition, chronic non-communicable diseases have become seven of the ten diseases that kill the most in the world. Thus, the impact of SAH on public health and its classification as a chronic non-communicable disease is reinforced, emphasizing the importance of focusing efforts on primary care to deal with the adversities associated with this disease [4].

Because Arterial Hypertension is a chronic condition, it is crucial to discuss its prevalence in the elderly population. According to Lopes' study, SAH is prevalent in approximately 65% of this population, contributing to 45% of deaths caused by cardiovascular diseases [5]. Therefore, the importance of a constant, habitual and controlled treatment for SAH is emphasized, which estimates blood pressure control and takes into account therapeutic adherence, since the inadequate control of this disease in the long term can lead to several other secondary damages such as renal failure, acute myocardial infarction and development of heart problems such as heart hypertrophy and heart failure [6].

In addition, in a population-based cross-sectional study conducted in Brazil, the prevalence of low adherence to treatment for chronic diseases was 30.8%, and only 2.6% of the interviewed population was classified as adherent [7]. Therefore, the results of the aforementioned research expose that the Brazilian population presents an obstacle to be faced with regard to the effective adoption of drug treatment.

Furthermore, uncontrolled SAH in the elderly is closely related to non-adherence to medication [8]. Thus, it is extremely important to address topics that may be negatively interfering with the process of pharmacological adherence by this population. For this, far beyond a quantitative approach, it is necessary to listen to the elderly actively, so that it is possible to understand which aspects are inducing difficulty in adhering to the therapeutic plan.

In addition, it is valid to resume that with the recurrence of diseases there is an increase in the frequency of use of medicines by the population, which has caused problems with regard to proper prescription, use, adherence, among others [2]. In addition to the increase in polypharmacy, the aging of the population also inferred changes regarding the prioritization of the preventive nature of health promotion actions, emphasizing that the coherent use of medicines is fundamental for the transformation of health policies [9].

In addition, the rational use of medicines is an agenda that surrounds the treatment of SAH, addressing a variety of topics such as the population's access to medicines in adequate doses and periods, seeking to minimize costs for patients and their communities, in addition to offering guidance and education on their correct use. This

approach seeks to contribute to the necessary changes in health policies in the face of the new demands of the population [4,9]. Therefore, in view of the obstacles presented by the irrational use of medicines, Consolidation Ordinance No. 2, of September 28, 2017, implemented issues related to the promotion of the rational use of medicines, proposing pharmacovigilance actions, training of professionals, encouragement of scientific and technological development, among others [10].

In the case of adherence to treatment and rational use of medication, it is evident that they are complex and multifactorial phenomena, so that it is necessary to take into account the cultural, social, psychological, physical and behavioral context of the patient so that, then, the development of the autonomy of the individual is feasible, who needs to attribute to himself an active role in health care [11]. Therefore, it is inferred that the doctor-patient relationship, far beyond being based on a prescription, must cover health education and the development of the patient's interest in adhering to treatment.

Moreover, it is significant that there are factors that imply adherence to drugs used for chronic diseases. Therefore, it is worth mentioning that low self-perception of health, side effects of pharmacotherapy, lack of availability and cost of medicines are one among many other factors that can intervene in the effectiveness of treatment for SAH. In addition, there are studies that prove the impact of polypharmacy on treatment adherence, showing that elderly people with a high prevalence of comorbidities demonstrate a significant reduction in the use of antihypertensive drugs [7].

Chronic diseases also have a significant impact on the psychology of patients. Thus, it is common that there is the development of feelings such as anxiety, fear and other emotions arising from the presence of the disease and all the anxieties and uncertainties that it carries. This reality converges to the magnitude that health education and qualified and humanized listening can exert in what follows the improvement of the patient's quality of life [12].

The understanding of the patient's perspective is endowed with a significant contribution to the understanding of the factors that are contributing to pharmacological non-adherence and, in a way, the long-term impacts that chronic disease provides. Therefore, the role of the qualitative study for the fulfillment of this purpose is evidenced, aiming to see the individual as endowed with values and expectations that result in different meanings in relation to the management of their condition [11].

In short, it is essential that the patient acquires confidence in the health team and in the process of changing habits, to prevent negative emotions and lack of knowledge from influencing adherence to pharmacological treatment. Therefore, it is necessary that in addition to the adequate supply and availability of medicines by the government entity, professionals accompany patients with chronic diseases in order to provide updated knowledge about the disease, promoting effective communication and setting tangible goals together [11,12].

Thus, the respective study aimed to broaden the understanding of non-adherence to the therapeutic plan of elderly people treated in Primary Health Care who are diagnosed with Systemic Arterial Hypertension. In addition, we sought to understand the factors, contexts and meanings that lead the elderly population not to adhere to the medication plan and to accept the perspective of the elderly for a better

understanding of the factors that negatively interfere with pharmacological adherence to the treatment of Systemic Arterial Hypertension.

Materials and Methods

It is a qualitative study, with description and content analysis, carried out in a Primary Healthcare Unit (UBS) based on the Family Health Strategy, located in the South Zone of the city of São Paulo. The choice of this location was motivated by the proximity and familiarity with the area of activity of the researchers' institution, seeking to facilitate the planning and implementation of the study, considering the previous experience with the reality of that community. Data were collected through interviews that conjecture pre-formulated questions, developed between January and February 2024 in home visits.

The study defined the target audience from the selection of a non-probabilistic and intentional sample. The subjects were selected from an agreement with the UBS, giving priority to patients classified as potential users with difficulties in adhering to treatment for SAH.

We included patients aged 60 years or older diagnosed with Systemic Arterial Hypertension (SAH), with or without other comorbidities, enrolled in the UBS and who were presenting difficulties in adhering to the therapeutic plan prepared by their health team. At the end, 20 patients who met the inclusion criteria were selected to compose the research sample.

For data collection, the project was approved by the Ethics and Research Committee with Human Beings of Universidade Santo Amaro and the Municipal Health Department of São Paulo under opinion no. 6,296,275 and 6,479,419, according to Resolution 466/12 of the National Health Council [13]. The research was also substantiated by the Term of Commitment and Confidentiality and the participants were informed about the purpose of the study and signed the Informed Consent Form.

From the list of users defined by the UBS, individuals who reported having difficulties in adhering to medication for the treatment of arterial hypertension were interviewed. Therefore, in-depth interviews were carried out in the homes of the research subjects, based on pre-scheduled home visits with the Community Health Agent (ACS). During these visits, patients who agreed to participate in the research were referred to the in-depth interview, which was based on the answer to triggering questions that aimed to motivate the subject to express beliefs, motivations, attitudes and sensations about a given subject [14]. Although the process had the full monitoring of the ACS in guiding the home visits, there was no participation of these professionals in the interviews, so that they were conducted solely and exclusively by the study researchers, who had no link or relationship with the health team of the basic unit where the research was carried out.

Thus, a questionnaire was applied during the home visit in order to detect difficulties regarding medication adherence by hypertensive patients who meet the criteria selected for the sample formulation. The questionnaire was prepared with open questions, seeking to understand how and why the elderly are facing difficulties in adhering to treatment. The questionnaire was based on the studies of Haynes and Oliveira, and adapted according to the needs of the research [15, 16]. In this adaptation, specific identification questions were added, in addition to more assertive questions for the extraction of information by patients.

This approach was developed with the purpose of maintaining an adequate number of questions with greater potential to stimulate participants' speech and promote more accurate answers.

The interviews were recorded by a mobile device and later transcribed manually, in order to make the research material more intelligible and facilitate the identification of thematic categories. In addition, for Queiroz, the manual transcription of an oral document to a written document is crucial for the reproduction of events, since the use of software to make transcriptions can change the veracity of what happened since intonation, emphasis and pauses used by the interviewer are inserted in a social and verbal context that can influence interpretation. Thus, the interview had to be transcribed manually in order to faithfully reflect the way the questions were formulated and answered [17].

The subjects submitted to the interviews had their names coded to maintain their privacy. Thus, the first respondent was identified as E1, the second as E2 and so on.

The data analysis was established from the Content Analysis technique of Laurence Bardin, so that the process was divided into three phases: pre-analysis, exploration of the material and treatment of the results obtained [18].

During the pre-analysis phase, the research material to be analyzed was organized. During this period, a floating reading of the material was carried out in order to define significant sections to compose the categories. After the organization, the second phase of exploration of the material was based on the application of what was defined in the previous phase, allowing the delimitation of the sections of interest, relating them to the categories created.

Thus, it was possible to proceed to the third and last phase, which concerns the treatment of the results obtained, in which it was necessary to create relationships between the data obtained with literary, scientific, academic manuals, health policies, among others.

Results

Among the 20 interviewees, the majority (80%) were female and the age of the participants ranged between 61 and 86 years. In addition, it was found that 65% were married, 20% were widowed, 10% were divorced and only 5% declared themselves single. As for polypharmacy drugs, in addition to antihypertensive drugs, most of the elderly used antidyslipidemics, antiplatelets, antidiabetics, proton pump inhibitors, among others.

The interviews were structured based on a previously formulated questionnaire, exploring the ideas and speeches and interpreting them based on theoretical references. This approach seeks to elucidate meanings that reverberate broadly in the selected study group. Thus, even with the peculiarities and diversities of the speeches obtained during the field phase, it was still possible to detect similarities and themes that presented themselves with greater intensity [14].

Thus, the analysis of the speech of non-adherent elderly resulted in the production of categories, classified from the discursive formations, discussed below. Therefore, during the interviews, the following categories that permeated the failures of therapeutic adherence were emanated: lack of adherence to medications due to memory failures, clinical perception and patient autonomy: misunderstandings about the impact of the disease, alcoholism, side

effects of pharmacotherapy, polypharmacy, superficial perception of benefits and low availability of medicines in the public network.

Lack of medication adherence related to memory failures

Memory failures were scored as an important factor in what is consistent with the production of interferences in adherence to a previously structured therapeutic plan:

> "Eu não sei nada, sei de nada. Nada. I don't "remember" anything, I forget everything. Eu sabia de mês, dos anos que eu nasci, os anos que meus pais "viveu", os anos que meus pais "morreu" e não sei mais de nada." [I know nothing, I know nothing. Nothing. I knew the month, the years I was born, the years my parents lived, the years my parents died and I know nothing anymore.] (E1)

> "Não te digo nada que eu sei [...] não me "alembro" de nada [...] eu só "alembro" de Deus, que eu não posso esquecer dele. Que ele tá me segurando aqui oh! Mas outra coisa não." [[I don't tell you anything I know [...] I don't remember anything [...] I just remember God, that I can't forget him. That He is holding me here oh! But not another thing.] (E1)

> "Às vezes eu esquecia…, mas agora como eu vi que eu passei mal e agora não tem ninguém pra me socorrer, aí eu tenho que tomar direto, né?" ["Sometimes I forgot…, but now that I've seen how ill I got and there's no one to help me, I have to take it regularly, right?"] (E19)

> "Ele [marido] não toma, porque disse que esquece." [He [husband] doesn't take it because he said he forgets.] (E20)

Although not a constant, the association between the use of medications appropriately and the change in daily habits can be a factor that interferes with medication adherence and contributes to forgetfulness:

> "Não! Agora… eu esqueci de levar o de pressão ontem "pra" tomar no caminho, né? Porque a gente saiu daqui cedo e eu não cheguei a levar. Só porque eu esqueci, né? Com aquele alvoroço de sair, né? Aí eu esqueci de colocar na bolsa." [No! Now... I forgot to bring my blood pressure medication yesterday to take on the way, right? Because we left here early and I didn't get to bring it. Just because I forgot, right? With all the commotion of leaving, right? Then I forgot to put it in my bag.] (E12)

> "Tem que demorar um pouco "pra" depois tomar os outros. Porque ontem eu me esqueci daquele… o da diabetes, que eu não tenho dormido direito, aí no outro dia com esse sono que eu "tô" tem noite que eu quase… era até "pra" falar com a doutora, "pra" ela passar um remédio "pra" dormir." [[You have to wait a while before taking the others. Because yesterday I forgot that one... the one for diabetes, which I haven't been sleeping well, so the next day, with how sleepy I am, there are nights when I almost... I was even going to talk to the doctor, so she could prescribe me some sleeping pills.]] (E18)

Therefore, the need for an individual analysis of each patient is reinforced, since in addition to variations in memory and cognition capacity, the issue of oscillations and peculiarities of daily life should also be explored to understand the difficulties of pharmacological adherence.

Clinical Perception and Patient Autonomy: misunderstandings about the impact of the disease

From the evaluation of the interviews, there is a misinterpretation of the clinical importance of Systemic Arterial Hypertension, so that there is no adequate perception by the elderly and/or caregivers of the severity and risks that the disease exposes them to:

> "É porque não se lembra que vai morrer! É, ele mesmo não sabe que qualquer hora infarta e aí morre. É... Deus toma de conta, né? Ele não liga não. Ele não tem medo não [...] falei: "[...] toma os remédios direito", aí eu vou, explico como é, aí ele 'ai, tomei três de uma vez', e aí é assim." ["It's because he doesn't remember that he's going to die! Yes, he himself doesn't know that he could have a heart attack at any moment and then die. Yeah... God will take care of him, right? He doesn't care. He's not afraid [...] I said: "[...] take your medicine properly," so I explain how it works, and then he says, "Oh, I took three at once," and that's how it is."] (E3)

> "Então! Eu "tô" medindo todos os dias, né? Tá entre 13, 14, 13, 14. Esses dias foi pra 18 e a língua dela enrolou [...] E aí chegou em 13, aí eu falei 'ah, agora fica monitorando', né, aí acabei nem levando, aí eu tenho que ver, né?" ["So! I'm measuring every day, right? It's between 13, 14, 13, 14. These days it went up to 18 and her tongue twitched [...] And then it got to 13, so I said, 'Oh, now keep monitoring it,' right, so I ended up not taking it, so I have to see, right?"] (E17)

> "[...] a pressão dela "tava" muito nas alturas. Ela não "tava" tomando as medicações direitinho e acabou tendo infarto, não foi?" ["[...] her blood pressure was really high. She wasn't taking her medication properly and ended up having a heart attack, didn't she?"] (E19)

In addition, self-care enables the elderly person to develop feelings of security and autonomy to administer their own treatment:

> "Na hora que eu vou tomar eu meço a pressão, se tiver normal eu não tomo. Agora se já tiver um pouquinho alta aí eu tomo o remédio." ["When it's time to take it, I measure my blood pressure. If it's normal, I don't take it. But if it's even slightly high, then I take the medicine."] (E13)

> "Olha, essa semana eu tomei [o medicamento da pressão] uma vez. Só uma vez, porque ela subiu. Hoje ela tá… hoje ela já tá… tá 11, eu já medi duas vezes. Hoje eu não tomei não." [Look, this week I took [my blood pressure medication] once. Just once, because my blood pressure went up. Today it's... today it's already... it's 11, I've measured it twice. I haven't taken it today.] (E13)

The feeling of autonomy for changes in therapy was also established by the attempt to reward delays in medication:

> "É… aí quando ele toma, ele toma… pode ser, ele toma dois, três ao mesmo tempo, engolindo tudo junto e ele fica meio tonto. [...] Sempre que ele toma, ele fica tonto. Aí eu digo, com vinho você não fica tonto e com remédio você fica." ["Yeah... when he takes it, he takes it... maybe he takes two or three at the same time, swallowing them all together, and he gets kind of dizzy. Whenever he takes it, he gets dizzy. Then I say, wine doesn't make you dizzy, but medicine does."] (E3)

It was found in some speeches that the failures in the follow-up of the proposed treatment also demonstrate a therapeutic strategy aiming at well-being and, therefore, are no longer seen as non-adherence to medication and are

interpreted by these elderly as an attitude of protection:

> "Se eu tomar o chá e não baixar aí eu já sei que eu tenho que tomar mais dois comprimidos ou se não tem que chamar ela mais o XXX "pra" me levar "pro" médico. [...] tomo chá, aí vai moderando, moderando, moderando. Aí eu vou ver "tá" 15 por 8. Amém! Não vou tomar remédio hoje [risos]." [If I drink the tea and it doesn't go down, I know I have to take two more pills, or else I have to call her and XXX to take me to the doctor. [...] I drink tea, and then it gradually goes down, down, down. Then I go check and it's 15 over 8. Amen! I'm not going to take any medicine today [laughs].] (E20)

> "Eu gosto muito de tomar é chá, que muitas das vezes o chá resolve mais do que os remédio aí [...] é mais saudável." ["I really like drinking tea, which often works better than medicine [...] it's healthier."] (E13)

Alcoholism

Alcoholism may have been an obstacle to pharmacological adherence in the studied population:

> "Eu "tava" tendo [dificuldades], porque eu "tava" bebendo… Eu "tava" bebendo. Bebia muito, tinha vezes que passava um mês sem tomar remédio, bebendo." [I was having [difficulties] because I was drinking... I was drinking. I drank a lot, there were times when I would go a month without taking my medication, drinking.] (E5)

> "Eu tinha medo de misturar bebida com remédio. [...] Quando eu tomava bebida eu não bebia o remédio e quando eu bebia o remédio eu não tomava a bebida, entendeu?" [I was afraid of mixing alcohol with medicine. When I drank alcohol, I didn't take my medicine, and when I took my medicine, I didn't drink alcohol, you know?] (E5)

> "Dificuldade é que ele toma no dia que ele quer! No dia que ele acha melhor tomar o vinho…" [The difficulty is that he drinks it on the day he wants to! On the day he thinks it's best to drink wine…] (E3)

The use of alcohol proved to be a psychosocial factor that negatively marked the pharmacological treatment, so that the use of alcoholic beverages became an exclusive factor for therapeutic adherence among the interviewees who consumed it. Changing this habit requires a lot of effort, given the need to break with behaviors that are often already rooted for various reasons such as social and cultural influences, daily conditions, among others.

Side effects of pharmacotherapy

The side effects arising from the proposed treatment result in an irregular use or interruptions in therapy:

> "É… eu "tava" fazendo muito xixi, que eu "tava" tomando. Aí eu parei." [Yes... I was peeing a lot, when I was taking it. Then I stopped] (E17)

> "Porque às vezes você toma um comprimido desse, você não pode tomar ele com o estômago vazio. Bom, pelo menos meu problema. Se eu tomar com estômago vazio me dá dor de estômago, já o chá não. O chá não me dá nada." [Because sometimes when you take a pill like this, you can't take it on an empty stomach. Well, at least that's my problem. If I take it on an empty stomach, it gives me stomach pain, but tea doesn't. Tea doesn't give me anything.] (E13)

> "É que ela fazia xixi tudo na roupa, não aguentava chegar no banheiro, né? E aí como ele é diurético e ela já tem incontinência urinária, aí ela parou. Mas será que prejudica? Que ela tá tomando propranolol."

> [She used to pee all over her clothes, she couldn't make it to the bathroom, you know? And then, since it's a diuretic and she already has urinary incontinence, she stopped. But could it be harmful? She's taking propranolol.] (E17)

> "Só que eu não gosto de tomar quando eu saio. Esse aqui, olha. Porque eu urino muito. Eu quase urino na roupa." [But I don't like taking it when I go out. This one, look. Because I urinate a lot. I almost urinate on my clothes.] (E19)

In this context, it is relevant to emphasize that the experience that the elderly have with pharmacotherapy can influence the adherence or non-adherence to treatment and, for this reason, longitudinal and individualized follow-up would be ideal to detect these problems and make adjustments in the prescription [11, 16]. In addition, despite not being a constant, it was observed in the speeches the correlation of non-adherence with the lack of understanding about the possible side effects of the drugs added to feelings of uncertainty:

> "Agora que ele começou que eu "tô" com medo e "tô" contando assim, por causa dessa disenteria dele, que "tô" achando que foi remédio, que eu "tô" dando muito remédio." [Now that he's started, I'm scared and I'm telling you this because of his dysentery, which I think was caused by medicine, because I'm giving him too much medicine.] (E4)

> "Mas aí ele "tava" dando umas manchas no braço dele, aí às vezes ele toma e às vezes não toma. Esse aí [AAS] ele não toma direito não [...] ele não toma, ele toma mesmo só quando tá com muita dor que aí eu dou pra ele, entendeu?" ["But then he had some spots on his arm, so sometimes he takes it and sometimes he doesn't. He doesn't take that one [AAS] properly [...] he doesn't take it, he only takes it when he's in a lot of pain, so I give it to him, you know?"] (E4)

Polypharmacy

With the aging process, the new need for the routine consumption of various drugs arises. Thus, during the analysis of the interviews, the impact of this new habit on drug adherence was detected:

> "Às vezes eu me engano e tomo um pensando que é outro. Às vezes eu… eu pego e penso que é ele, mas não é ele" [Sometimes I make a mistake and take one thinking it's another. Sometimes I... I pick it up and think it's the medicine, but it's not it] (E11)

> "Então não "tava" sabendo. Aqui "tava" tudo desorganizado, que eu me… desorganizada, menina! Eu não vou negar. Eu tenho que parar pra colocar um por um (na caixa de organização)." ["So, I didn't know. Everything here was disorganized, and I was... disorganized, girl! I won't deny it. I have to stop and put everything away one by one (in the storage box)."] (E19)

It was also observed that some elderly, in addition to managing their own care, also had the role of caregivers in the environment in which they were inserted. Therefore, polypharmacy combined with the overload of these individuals is installed as a confounding factor:

> "É esse aqui que eu tenho mais dificuldade. É esse aqui, que ele tem que tomar quatro comprimidos por dia. Esse eu "tô" meio perdida, perdidinha da vida, porque é quatro vezes "o" dia. Aí é pra ser dois no café, um no almoço e um na janta e ele só tá mais tomando mais é de manhã." [This is the one I have the most trouble with. It's this one, he has to take four pills a day. I'm kind of lost with this one, completely lost, because it's four times a day. It's

> supposed to be two at breakfast, one at lunch, and one at dinner, but he's only taking them in the morning.] (E4)

In addition, when asked about the drugs used, there was some difficulty on the part of the elderly in remembering the names of the specific drugs they were taking, which can also be attributed to the fact that they were using multiple drugs simultaneously.

> "Vish Maria. É isso meu problema, que eu tenho que achar a receita pra te dar pra você ver." [Oh my God. That's my problem, I have to find the recipe to give you so you can see.] (E5)

> "Vish… Falar tudo agora não vou lembrar não." ["Oh dear... I won't remember everything if I say it all now."] (E8)

> "[...]Eu tenho que pegar, né? tiazida e outro branquinho que eu não sei o nome dele, é ben… não sei o que. É três de pressão." [I have to take it, right? Thiazide and another white one that I don't know the name of, it's ben... I don't know what. It's three for blood pressure.] (E10)

> "Eu sei! O de pressão né? O de diabetes e AAS, e qual é o outro meu Deus?… é quatro né, XXX? Não, de colesterol eu não tomo não, de colesterol não." [I know! The blood pressure one, right? The diabetes and ASS one, and what's the other one, my God? ... It's four, right, XXX? No, I don't take cholesterol medication, not cholesterol.] (E12)

> "Eu tomo… Vish Maria, não sei dizer. Eu não sei falar o nome todo. Pera aí! [pausa] Então, são esses daqui, olha. Sinvastatina, va-vasopril…" ["I take... Oh God, I can't say. I don't know how to say the whole name. Wait a minute! [pause] So, it's these ones here, look. Simvastatin, va-vasopril..."] (E16)

Superficial perception of benefits

In addition to having a misunderstanding of the severity of Systemic Arterial Hypertension, when asked about the benefits of drugs, some elderly people presented a superficial perception:

> "Eu "tô" tomando uns remédios que tem aí que eu nem sei nem pra que que serve. Tem pessoal que fala "pra que que serve esse remédio?" e eu "não sei" …" [I'm taking some medication that I don't even know what it's for. Some people ask, "What is this medication for?" and I say, "I don't know"...] (E5)

> "Ó, eu sei… é esse que eu não sei pra que que serve. Eu sei que esse aqui [losartana] é pra ajudar fazer urina, xixi, né?" ["Oh, I know... that's the one I don't know what it's for. I know this one [losartan] is to help you pee, right?"] (E5)

> "Pra ficar bem ou melhorar." [To stay well or get better.] (E8)

> "Benefícios pra minha saúde, né? faz bem, né?" [Health benefits, right? It's good for you, isn't it?] (E10)

> "Serve pra pressão alta… pra diabete… pro colesterol. É isso." ["It's good for high blood pressure... diabetes... cholesterol. That's it."] (E11)

> "É pra pressão." [It's for blood pressure.] (E14)

> "É… é por causa da pressão, né? Pra não subir" [It's... it's because of the pressure, right? So it doesn't go up.] (E16)

> "Não sei não." [I don't know.] (E17)

> "Minha "fia", porque deixa de subir a pressão, né? Somente." [My dear, because it makes your blood pressure stop rising, right? That's all.] (E20)

Low availability of medicines in the public network

Lack of access to medicines can be an aggravating factor of the difficulty of therapeutic adherence. Thus, during the interviews, the lack of some medicines in the public health network was found:

> "Furosemida, não sei pra que é, que não tinha no posto e eu me lembro do nome." ["Furosemide, I don't know what it's for, they didn't have it at the clinic, and I remember the name."] (E3)

> "Dos três eu já vi faltar um, e aí o que eu não deixava faltar mesmo era o losartana que eu acho que é o de pressão. Mas os outros também "interfere" nisso aí também. E aí eu logo procurava ele, né, faltava ele e eu pedia a minha cunhada, não sei se ela tem." [Of the three, I've seen one go missing, and what I really didn't want to run out of was losartan, which I think is for blood pressure. But the others also interfere with that too. So I would look for it right away, right? If it was missing, I would ask my sister-in-law, I don't know if she has it.] (E15)

> "Esse daqui, oh. Eu to comprando, minha "fia" [...] Não é barato não, minha "fia". O comadre compra lá naquela farmácia daquele homem que eu não sei como é que chama." [This one here, oh. I'm buying it, my dear [...] It's not cheap, my dear. My friend buys it at that pharmacy owned by that man whose name I don't know.] (E20)

> "Toma dois "tipo" de remédio, aí toma o comprimido dele tomar de manhã, aí eu já ponho aqui junto com losartana pra ele não esquecer. Aí o outro já deixo aqui e ele toma dois. Esse outro é comprado… E é caro!" [He takes two types of medicine, then he takes his pill in the morning, so I put it here together with losartan so he doesn't forget. Then I leave the other one here and he takes two. This other one is bought... And it's expensive!] (E20)

In addition, the importance of the monetary value of medicines as a factor in ensuring access to them was evidenced:

> "Eu compro porque é barato, né? Meus "remédio" é baratinho, né? Tem remédio de gente por aí, de gente… eu não vou dizer de tanto idoso, aposentado aqui… até de criança, sei lá… que é um dinheirão danado, né? A gente vê na reportagem por aí, é um dinheirão danado." [I buy it because it's cheap, right? My "medicine" is cheap, right? There are medicines out there, for people... I'm not going to say for the elderly, retirees here... even for children, I don't know... that cost a lot of money, right? We see it in the news, it costs a lot of money.] (E15)

The report of greater financial difficulties was also accompanied by a decrease in adherence when the drug was missing in public health services:

> "Meu marido saiu. Saiu domingo, foi embora pra Bahia, tá esperando um bom tempo por lá. Aí ele não… não sei se ele vai mandar ou não, né? E minha bolsa família bloqueou. Eu já fui lá atualizar e não saiu nada até hoje [...] quando eu posso e eu recebo do menino, eu compro, "tendeu"? Muito tempo eu deixei de comprar, porque eu não tinha como. Eu não tomava. Só esse daqui e aquele rosa, mas os outros…" [My husband left. He left on Sunday, went to Bahia, and is waiting there for a while. So he doesn't... I don't know if he'll send it or not, right? And my Bolsa Família has been blocked. I already went there to update it and nothing has come through yet [...] when I can and I get money from my son, I buy it, you know? I stopped buying for a long time because I couldn't afford it. I didn't

take it. Just this one here and that pink one, but the others...] (E19)

Discussion

The interviews analyzed in the respective research showed a common phenomenon: non-adherence to medication as a multifactorial factor. From this, the importance of an perspective based on the conception of the health-disease process for elderly individuals is emphasized, in contradiction to the traditional conception of medicine, which sees only the biological events that occur in the individual [19]. Thus, knowledge from the perspective of the elderly symbolizes an important contribution in the perspective of medication adherence [11].

During the interviews, it was noticed that many elderly people declared that they had no difficulties in the use of medications for hypertension, however these statements were soon replaced by statements that demonstrated weaknesses in therapeutic adherence. This occurrence shows the lack of knowledge about the correct use of medicines, which still intervenes in adherence failures [11]. In addition, studies indicate that a significant portion of the elderly population has limited knowledge about their medications, and misunderstanding about the instructions for drug therapy often comes from multifactorial factors, which is consistent with the results of this study.20,21

The early detection of obstacles to drug adherence can contribute to the optimization of therapy, resulting in cost reduction and better control of blood pressure [22]. Thus, analyzing the statements of the present study, forgetfulness was one of the factors that contributed negatively to the compliance of the elderly with the proposed therapeutic plan.

Nevertheless, one reported aspect that permeated the memory failures were the changes in the daily routine. Thus, the need to analyze the individuality in the treatment of each individual is reinforced, in addition to exploring the daily routine of the patient to establish agreements between users and professionals, in order to incorporate an effective therapy [16].

Another important factor that was posed as a challenge for adherence during the course of the interviews was cognitive deficit. According to an observational study conducted with 436 elderly patients, cognitive impairment was a factor independently associated with the risk of non-adherence to medication among patients with chronic diseases.[23] In addition, another cohort study involving the elderly population, the risk of non-adherence was twice as high in those who had some cognitive impairment when compared to those who did not.[24,25] Thus, caregivers and family members gain an important role in contributing to greater pharmacological adherence by the elderly who have cognitive impairment.[24]

The lack of knowledge about arterial hypertension has as a consequence the establishment of a certain disinterest in the disease.[26] The lack of knowledge about the condition itself and the drug therapy is a factor that contributes to the low adherence to treatment in patients with chronic diseases, either by the reduced perception of the severity of the disease, uncertainties about the drugs or failures in communication between patient and health professionals.[27,28,29] The expression of this phenomenon was verified in the respective study, so that the interviewees presented certain lapses in understanding the vulnerability and

severity of Systemic Arterial Hypertension, thus, the risk that they were submitting themselves to by not adhering to the treatment ceased to be a factor valued enough for there to be an effective adherence.

In this sense, the relevance of the user's perspective on the disease process itself is reinforced, since the lack of understanding about their own condition can be a factor to corroborate the lack of adherence [11]. In addition, the lack of critical reflection on the part of the user, combined with a disregard for the possible consequences that the disease can provide, has proved to be an ally in the ineffective follow-up of the treatment.

Another phenomenon identified during the interviews as an obstacle to medication adherence was the self-care of hypertensive patients, being a triggering factor for the development of feelings of autonomy, which has as a consequence the installation of security on the part of the elderly in managing their own treatment. When analyzing the participants' statements, it is noted that these deviations in the therapeutic plan can be interpreted by the patients as a form of precaution in relation to their health, instead of being seen simply as a lack of compliance with the treatment. [16]

In addition, the lack of understanding of the information that matches the treatment and the inability to associate this information with the correct use can contribute to the individual's vulnerability to established cultural conceptions that expand beyond conventional medicine and encompass popular therapy.[30, 31] Therefore, beliefs put the individual in a position of involuntary acceptance, as it establishes their assimilation without proper proof of the truth.[32] Thus, the incorporation of these conceptions can contribute to pharmacological non-adherence from a scientific point of view by integrating with the feeling of autonomy, causing the individual to base their treatment on their own beliefs.

Non-adherence is a phenomenon that is related to several factors such as age, income, alcoholism and how to relate to health services.[33] In addition, several psychosocial elements such as lack of motivation, social and cultural influence, beliefs and self-confidence can positively or not impact lifestyle changes [11]. Thus, alcoholism as an obstacle to drug adherence can be explained by the context in which individuals are inserted and by the uncertainties combined with the lack of perception of relevant factors that permeate the treatment and diagnosis. In addition, evidence indicates that alcohol abuse in patients with chronic diseases is closely associated with low adherence to drug therapy. [34]

It was also found that the side effects of the drugs were a contributing factor to the interruption of treatment continuity. It is observed from the participants' statements that the disease ends up being permeated by fears and uncertainties and, from this, the elderly make use of their autonomy to discontinue pharmacotherapy in order to avoid damage and complications. This phenomenon shows that patients' access to medicines and health services are not a guarantee that the treatment will be carried out correctly, which highlights the importance of a constant evaluation by health professionals, in order to assess the need for maintenance and risk-benefit of the use of certain medicines, taking into account the side effects and how much they impact the lives of the elderly. [16, 30] In addition, the importance of considering that access to medicines for non-communicable diseases can be influenced by several factors, including the structure of the health system and individual characteristics of patients, is proven, demonstrating that even when

there is availability of treatment, logistical and socioeconomic obstacles can compromise drug adherence. [35]

With the aging process, the regular use of drugs is a new lifestyle habit to be adopted, however, this change may encounter resistance among the elderly, especially when the administration of drugs is complicated and requires frequency. [16] In view of this, during the interviews it was observed that polypharmacy can be characterized as an obstacle to optimal pharmacological adherence. The complexity of therapeutic schemes often results in low adherence, especially among uneducated patients, which can compromise the control of chronic diseases and increase the risks of complications.[36,37] Therefore, there is an urgent need to develop strategies that favor the use of the drug by the elderly, in addition to the co-participation of the family and/or caregivers, in order to help the elderly in the process of self-care and coping with Systemic Arterial Hypertension, since polypharmacy, in addition to challenging drug adherence, also impacts the quality of life of patients, making it essential to adopt an individualized approach. [30, 38, 39, 40] In fact, Inouye (2021)[41] highlights that polypharmacy and the inappropriate use of medications are a challenge for healthcare, and lists ageism as an influential factor in the use of potentially inappropriate medications in a polypharmacy context. Collaboration with clinical pharmacists, emphasis on adverse reactions and drug interactions, and the application of pre-established criteria to reduce exposure to polypharmacy are essential to mitigate this problem.

The superficial perception of the benefits of treatment for SAH was also a factor detected during the interviewees' speeches. This fact combined with the low perception of the severity of the disease can aggravate poor adherence, since the understanding of health conditions is linked to a better quality of life and can facilitate acceptance and, therefore, better contiguity with the proposed treatment. [12]

In the practical scenario, pharmacological non-adherence is also related to the economic factor and the availability of medicines in the public health network, as evidenced by the interviews. A study carried out with individuals treated at an integrated health center revealed that 38% of patients faced difficulties in adhering to treatment due to financial limitations in acquiring the drugs. [42] In addition, the uninterrupted and prolonged use of medicines by patients with chronic diseases implies financial costs, which ends up influencing treatment adherence [30]. Thus, the free availability and equal access to medicines play a crucial role in the effectiveness of adherence to treatment, especially for those who face financial difficulties to bear the costs. Therefore, the free distribution of medicines in addition to increasing adherence can improve self-monitoring, reduce missed primary visits and, in the long term, reduce overall health costs. [43,44]

Conclusion

In an attempt to understand the factors that permeate the difficulty of medication adherence from the perspective of hypertensive elderly, it was found that therapeutic adherence has multifactorial influences. In general, it was possible to recognize some factors that contribute to the worsening of this phenomenon such as changes in routine, memory failures, cognitive deficits, polypharmacy, alcoholism, effects produced by medicines, misperception about the clinical impact of the disease,

difficulty in accessing medicines, among others.

Thus, the importance of care that adopts the perspective of the health-disease process in a holistic way is reinforced again, allowing the identification of the feelings underlying the diagnosis and treatment. In this sense, the implementation of a Health Education guided by the needs of the individual becomes essential, since, in the respective context, it is necessary to apply an educational approach, which must be based on the understanding of the user as a biopsychosocial being, taking into account the individuality of patients and their demands [45].

In addition, with regard to the promotion of adherence to treatment and better health outcomes, in addition to the execution of a humanized service with an educational approach, it is essential that there is a guarantee of equal access to medicines, meeting the needs of users and contributing to a more equal and effective health implementation. Therefore, the recognition of the challenges surrounding medication adherence favors the creation of strategies that encourage the practical reinforcement of the principles of the Unified Health System, with consequent improvements for the population.

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