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Accessibility of users with hypertension in the family health strategy

Acessibilidade dos usuários com hipertensão arterial sistêmica na estratégia saúde da família

La accesibilidad de los usuarios con hipertensión arterial sistémica en la estrategia de salud de la familia

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Abstract

Objective: To evaluate the accessibility of hypertensive patients in the Family Health Strategy in Campina Grande/PB. **Methods:** This is a descriptive cross-sectional study, conducted with the hypertensive population enrolled in HiperDia (n = 17,658) from a sample of 382 users. An instrument adapted by Paes of the validated instrument to assess attention to TB proposed by Villa and Ruffino-Neto was used. **Results:** It was obtained satisfactory results regarding the geographical accessibility: 4.10 (CI 95% [3.56 to 4.65], SD = 0.518) and economic: 4.10 (CI 95% [3.56 to 4.65], SD = 0.518). As for organizational accessibility: 3.46 (CI 95% [2.70 to 4.22], SD = 0.724) and socio-cultural: 3.42 (CI 95% [2.79 to 4.05], SD = 1.090), regular results were obtained. **Conclusion:** According to the satisfaction of the hypertensive patients in Campina Grande/PB provided access to family health strategy without geographic and economic barriers, but there were problems with the organizational and socio-cultural aspects.

Keywords: Hypertension; Accessibility to health services; Health services evaluation.

Resumo

Objetivo: Avaliar a acessibilidade dos usuários hipertensos na estratégia de saúde da família no Município de Campina Grande/PB. **Métodos:** É um estudo transversal e descritivo, realizado com a população de hipertensos cadastrados no HiperDia (n = 17.658) a partir de uma amostra de 382 usuários. Foi utilizado um instrumento adaptado por Paes do instrumento validado para avaliar a atenção para a tuberculose proposto por Villa e Ruffino-Neto. **Resultados:** Obtiveram-se resultados satisfatórios referentes à acessibilidade geográfica: 4,10 (IC 95% [3,56-4,65]; DP: 0,518) e econômica: 4,10 (IC 95% [3,56-4,65]; DP: 0,518). Quanto à acessibilidade organizacional: 3,46 (IC 95% [2,70-4,22]; DP: 0,724) e sóciocultural: 3,42 (IC 95% [2,79-4,05]; DP: 1,090), obteve-se resultados regulares. **Conclusão:** De acordo com a satisfação dos usuários hipertensos o Município de Campina Grande/PB proporcionou acesso à estratégia saúde da família sem barreiras geográficas e econômicas, porém apresentou problemas em relação aos aspectos organizacionais e sócioculturais.

Palavras-chave: Hipertensão; Acessibilidade aos serviços de saúde; Avaliação de serviços de saúde.

Resumen

Objetivo: Evaluar la accesibilidad de los pacientes hipertensos en la Estrategia Salud de la Familia, en Campina Grande/PB. **Métodos:** Se realizó un estudio descriptivo, transversal, realizado con la población de hipertensos inscritos en el HiperDia (n = 17.658) de una muestra de 382 usuarios. Se utilizó un instrumento adaptado por Paes, instrumento validado para evaluar la atención a la tuberculosis, propuesto por Villa y Ruffino-Neto. **Resultados:** Los resultados obtenidos fueron satisfactorios en cuanto a la accesibilidad geográfica: 4,10 (IC 95% [3,56-4,65], DE = 0,518) y económica: 4,10 (IC 95% [3,56-4,65], DE = 0,518). En cuanto a la accesibilidad organizacional: 3,46 (IC 95% [2,70-4,22], DE = 0,724) y socio-cultural: 3,42 (IC 95% [2,79-4,05], DE = 1.090), fueron detectados resultados regulares. **Conclusión:** De acuerdo con la satisfacción de los usuarios hipertensos, el municipio de Campina Grande les garantía buen acceso a la estrategia de Salud de la Familia, sin barreras geográficas o económicas. Sin embargo, ha presentado problemas en los aspectos organizacionales y socioculturales.

Palabras-clave: Hipertensión; Accesibilidad a los servicios de salud; Evaluación de servicios de salud.

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INTRODUCTION

The systemic arterial hypertension (SAH) is one of the most common diseases of the modern world and reaches, on average, 15% to 20% of the adult population. In Brazil there are about 17 million patients with hypertension; 35% of the population is more than 40 years old. The burden of disease represented by the morbidity and mortality of this clinical entity is very high and is being treated as a serious public health problem throughout the world for its magnitude, risk and difficulty of control[1,2].

The Northeast region has 31.8% of individuals with hypertension, taking the city of Recife/PE on leadership of ranking with more than 29% of the population victim of the disease. The list also included João Pessoa/PB (23.9% of the population), Salvador/BA (23.4%), Natal/RN (22.6%) and Aracaju/SE (21.4%)[3].

To succeed in reducing these indicators of the morbidity and mortality of SAH, the plan of reorganization of the attention to Arterial Hypertension and *Diabetes Mellitus*, operated by the Family Health Strategy (FHS), has a fundamental role, needing the use of mechanisms that have as their purpose the implementation of the fundamental principles and guidelines for the implementation of a universal, integral and unanimous system to the entire population[4].

In this sense, the accessibility to health services contributes to this success, comprising one of the aspects of the supply of services relating to the ability to produce services and respond to the health needs of a given population, explaining the variations in the use of health services and population groups representing an important dimension in studies on equity in health systems[5].

Considering the scarcity of studies in the advance of knowledge related to accessibility evaluation of health services, especially in the northeastern region and assistance to SAH focused on FHS, the objective is evaluating the accessibility of hypertensive users to the Family Health Strategy (FHS) in the municipality of Campina Grande/PB.

METHODS

Cross-sectional study, of descriptive character, of health services evaluation. Held in Family Health Basic Units (FHBU), during the period from August 2009 to March 2010. The municipality of Campina Grande/PB, was one of the pioneers in the implementation of the Family Health Program (FHP) in 1994, with five teams, occurring the implementation process, 92 teams arriving in 2011, totaling 85% population coverage.

The target population was registered in hypertensive HiperDia Information System (System of Registration and Follow-up of Hypertensive and Diabetics) in 2006 and 2007, composed of 17,658 users. HiperDia is for the registration and follow-up of patients with hypertension and/or *diabetes mellitus* met in ambulatory network of SUS, generating information for acquisition, dispensing and distribution of medicines regularly and systematically to all registered patients.

A representative sample was calculated, using a sampling procedure by conglomerates (in two successive stages), with probability proportional to size (PPS), reaching 420 hypertensive, generating a total of 14 hypertensive per team, however, after identifying some losses (change of address, deaths, etc.), the sample was of 382 hypertensive.

As inclusion criteria, FHBU who had number of registered hypertensive (2006 and 2007), sheets and charts of the users was chosen.

Users below 20 years old, unable to answer the questionnaire by themselves and who performed the change described in the FHBU area during the registration period to the time of the interview were excluded.

It was used an instrument adapted for Paes[6] to evaluate the arterial hypertension services, based on a validated instrument to assess the tuberculosis proposed by Villa and Ruffino-Neto[7], guided by Starfield instrument[5], to evaluate primary healthcare in developed countries, consisting of 7 dimensions (access to diagnosis, access to treatment, adhesion/bond, cast of services, coordination, focus on the family, orientation to the community), totaling 100 variables. After their analysis, 40 variables relating to accessibility were chosen, grouped in 04 dimensions: geographic (07), economic (06), organizational (13) and sociocultural (14).

To evaluate the geographical accessibility, variables related at the onset of symptoms and during the consultation to SAH (health service nearest their home; difficulty to go to the health service and use of motorized transport to go to the health service) were observed.

The economic accessibility was evaluated by observing the variables related to the onset of symptoms and during the consultation SAH (use of motorized transport, waste of money with transport and loss of work shift or appointment to consult on health service).

Organizational accessibility was evaluated by observing variables related to the presence of professionals in the health unit in every working day of the week, hours of operation of the health service, wait times for servicing (over 60 minutes), appointment within 24 hours at the health unit, treatment, participation in groups, performance and receipt of requested examinations, reference and counter-reference.

Socio-cultural accessibility was evaluated by observing variables related to communication between professionals and users, the professional relationship with the community, the involvement of professionals with the family of the users and if there is a change of the unit because of the health professionals.

Data collection was carried out during the period from August 2009 until March 2010. The trajectory of the hypertensive registered users during the period was traced through the obtaining of information collected in two steps: secondary data (Information of the registers and records of hypertension) and primary data (the interviews were carried out in FHBU and when desired by the user, held in their homes).

The instrument was applied (structured questionnaire) through interviews with users, who answered questions, following up a range of possibilities for "Likert" (Never, Rarely, Sometimes, Often, Always), which attributed the value between 1 and 5. The categories "does not apply" were added, which assigned the value 0 (zero) and "don't know" or "not answered", where assigned the value 99.

A composite index was formed, general average, for each dimension of accessibility, through the sum of the average values of the questions. They were analyzed individually through the measures of central tendency and variability (mean, standard deviation and confidence interval).

Accessibility was classified in results: satisfactory (≥ 4); regular (< 4 and ≥ 3) and unsatisfactory (< 3).

The data were organized into spreadsheets in Office Excel 2003 and transferred to a database developed in IBM SPSS Statistics package 13.0. Then the identification of normality was performed, by the Kolmogorov-Smirnov test. As normality of distribution was not observed, the non-parametric test Kruskall-Wallis (non-parametric ANOVA) was used. Once applied the tests to compare the differences, by assigning a significance level of $p < 0.05$, a test known as multiple comparison "Dunn" was carried out.

The study was approved by the Ethics Committee in Research of the Health Sciences Center of Federal University of Paraiba (UFPB), through the Protocol 0101, being in accordance to Resolution 196/96 of the Ministry of Health.

RESULTS

Geographic Accessibility

Table 1 shows that the geographical accessibility in general, obtained satisfactory results, considering the composite index, with an average of 4.01 (CI 95% [3.56-4.46]; SD: 0.427). However it presented regular results in variables that have addressed the onset of symptoms of SAH, having presented a variability (SD) for highest for related variables during query for SAH.

Economic Accessibility

Table 2 shows that the economic accessibility in general, obtained satisfactory results, considering the composite index, with an average of 4.10 (95% CI [3.56-4.65]; SD: 0.518), featuring regular results in variables that have addressed the onset of symptoms of SAH, showing a variability (SD) for highest for related variables during query for SAH.

Organizational Accessibility

Table 3 shows that the organizational accessibility obtained regular result, with a composite index 3.46 (CI 95% [2.70-4.22]; SD: 0.724). It is observed that, for the most part, where the average indexes for items were below 4, the variability (SD) of responses were higher, than for the items whose indexes stayed above 4, i.e. the smaller the average index, the greater the dispersion of answers.

Socio-cultural accessibility

Table 4 shows that sociocultural accessibility obtained regular result, with a composite index 3.42 (95% CI [2.79-4.05]; SD: 1.090). A satisfaction in relation to variables that have addressed communication between users and professionals. However unsatisfactory results were observed related to variables that have addressed the involvement of professionals with the community and the family of the user.

DISCUSSION

The geographic and economic accessibility achieved in general, a satisfying composite index, providing easy to move without financial expense to the health service, by configuring the FHS as gateway health services network of the municipality for attention SAH.

The results shown are positive, because it features a greater demand of users by FHS, making the strengthening of primary care in controlling HAS advocated by health policies and programs of primary care responsibility[8].

The study confirms the Reorganization Plan of Care to Arterial Hypertension and *Diabetes Mellitus* in Brazil, which includes its general objective as the establishment of guidelines and objectives for the reorganization of care to arterial hypertension and diabetes in the Unified Health System (SUS), through ensuring diagnosis and user binding to health units for treating and monitoring[4].

The regular result presented by organizational accessibility through composite index was due to the behavior of the variables that have addressed various aspects.

Among them, the presence of professionals in the health unit in every working day of the week and the hours of operation of the FHBU, with satisfactory results. The study corroborated with what is advocated by the Ministry of Health, where all members of the FHS must have a load time of 40 hours per week, with the exception of medical professionals, and with the study presented in the vast majority of municipalities in northeastern Brazil, the FHS works in two daily shifts[8,9].

Regarding the waiting time, the study showed regular results (onset of symptoms of SAH) and unsatisfactory (in consultation with the SAH), opposing other studies, which have shown good results and excellent in relation to waiting time for scheduled consultations on FHBU, but in relation to urgent consultations obtained 50.3% regular and good results[10,11].

In a study conducted in municipalities in the Brazilian Northeast, users have confirmed there is great demand for assistance, with permanence of queues in FHBU, with waiting time for consultations, generally ranging from 1 to 7 days, and some capitals, the waiting time was greater, between 8 to 15 days[9].

Table 1. Average, Standard-Deviation and Confidence Interval of geographical accessibility indexes of hypertensive people registered in Hiperdia in the period of 2006-2007, Campina Grande/PB, 2011

Variable	Average	SD	Confidence Interval (95%)	
			Min.	Max.
1. When you began to have symptoms of SAH (headache, dizziness), did you search the closest health service from home?	3.79	1.762	3.60	3.98
2. When you began to have symptoms of SAH (headache, dizziness) did you have difficulty to go to the health service?	3.87	1.626	3.69	4.05
3. When you began to have symptoms of SAH (headache, dizziness), did you need to use some sort of motorized transport to go to the health service?	3.61	1.825	3.41	3.81
4. Do the health unit workers follow up your treatment of SAH usually visit you at home?	3.72	1.659	3.55	3.89
5. Do you do the treatment of SAH on a health service closer to home?	4.62	1.093	4.51	4.73
6. Do you have difficulty to go to the health unit to be consulted?	4.49	1.215	4.36	4.62
7. When you go to the health unit to consult your problem of SAH do you need to use motorized transportation?	4.71	1.012	4.60	4.81
Composite index	4.01	0.427	3.56	4.46

Geographical accessibility: Satisfactory (≥ 4); Regular (≥ 3 and < 4); Unsatisfactory (< 3); SAH: Systemic Arterial Hypertension; SD: Standard-Deviation; Min.: Minimum/Max.: Maximum. Source: Study held by Paes[6].

Table 2. Average, Standard-Deviation and confidence interval of economic accessibility indexes of hypertensive people in Hiperdia registered in the period 2006-2007, Campina Grande/PB, 2011

Variable	Average	SD	Confidence Interval (95%)	
			Mín.	Máx.
1. When you began to have symptoms of SAH (headache, dizziness), did you need to use some sort of motorized transportation to go to the health service?	3.61	1.825	3.41	3.81
2. When you began to have symptoms of SAH (headache, dizziness), did you spend money on transportation to go to the health service?	3.69	1.786	3.48	3.90
3. When you began to have symptoms of SAH (headache, dizziness, did you lose the work shift or any appointment to consult in the health service?	3.76	1.626	3.57	3.94
4. When you go to the health unit to consult your SAH problems, do you lose your work shift or any appointment?	4.11	1.386	3.96	4.26
5. When you go to the health unit to consult your SAH problem, do you need some sort of motorized transportation?	4.71	1.012	4.60	4.81
6. When you go to the health unit to consult, do you pay for transportation?	4.77	0.908	4.66	4.88
Composite index	4.10	0.518	3.56	4.65

Economic accessibility: Satisfactory (≥ 4); Regular (≥ 3 and < 4); Unsatisfactory (< 3); SAH: Systemic Arterial Hypertension; SD: Standard-Deviation; Min.: Minimum/Max.: Maximum. Source: Study held by Paes[6].

Through the opinion of users on access in another study, it was possible to verify the existence of a positive attitude in the face of SUS from the repeated references to the amenities found within the system to access the several types of services, from the basics, such as medical care, tests and medicines, until the access to resources of high complexity, such as transplants and more specific medications. However, despite the ease of access are identified difficulties also scored, as the excess of people to be served and the scrapping of the health units, objectified in the image of "queues" and "need to arrive at dawn to get the service"[12].

Medicine treatment was satisfactory in the study. It has great importance in reducing morbidity and mortality from cardiovascular disease, and SAH among the most prevalent

Table 3. Average, Standard-Deviation and Confidence Interval of organizational accessibility indexes of hypertensive in Hiperdia registered in the period 2006-2007, Campina Grande/PB, 2011

Variable	Average	SD	Confidence Interval (95%)	
			Min.	Max.
1. When you began to have symptoms of SAH (headache, dizziness) and sought the health service to consult, did it take more than 60 minutes to be assisted?	3.16	1.622	2.98	3.34
2. If you get sick because of medication or SAH, can you get an appointment within 24 hours at the health unit that makes treatment?	3.29	1.757	3.10	3.47
3. Since you began your treatment for SAH, was there lack of medicine?	4.15	1.070	4.04	4.26
4. When you go to the health unit to consultation, does it take more than 60 minutes to be assisted?	2.87	1.548	2.71	3.03
5. Can you perform examinations requested by the healthcare professional that follows up your treatment?	4.55	0.954	4.45	4.64
6. In the period of 10 days can you receive the results of the examinations requested by the healthcare professional that follows up your treatment?	2.76	1.544	2.60	2.92
7. Do you find a professional in the health unit to assist you in every working day of the week?	4.55	0.906	4.46	4.65
8. Participação em grupos de doentes de HAS na unidade de saúde?	2.59	1.764	2.41	2.77
9. Are the operation schedules of the health service for assistance always respected?	4.71	0.758	4.63	4.79
10. Do you receive all necessary medicines for the treatment of SAH?	4.40	1.247	4.27	4.53
11. When you have a health problem, do you receive a written referral to another health service by the professional that follow up your treatment?	4.51	1.177	4.36	4.65
12. When you have a health problem and is forwarded to another health service, do you have a guaranteed assistance at the new service?	4.73	0.816	4.63	4.83
13. Do you returns to the health unit with written information about the results of the consultation held in another service?	2.51	1.809	2.28	2.74
Composite index	3.46	0.724	2.70	4.22

Organizational acessibility: Satisfactory (≥ 4); Regular (≥ 3 and < 4); Unsatisfactory (< 3); SAH: Systemic Arterial Hypertension; SD: Standard-Deviation; Min.: Minimum/Max.: Maximum. Source: Study held by Paes[6].

and there is a direct relationship between the unsatisfactory control of blood pressure of hypertension and low adherence to medicine treatment, providing a further framework and increasing spending on secondary and tertiary care. The public health service, in particular the FHS, is responsible for promoting free access to population[2,13].

Studies conducted in the southern and northeastern regions of Brazil, viewed positive points, having a high prevalence of access to medicines of continuous use and receipt of medicines by 2/3 of the users to treat chronic diseases, as SAH[14].

There was no satisfaction of users in relation to the participation of groups for SAH. It becomes worrisome, because it is considered that the health education groups must be performed in an interactive way, integrating the professional group, causing users to be able to reflect and criticize their reality, discussing the most common problems among themselves and exchange experiences. Health professionals must adapt the information to the needs of individuals and the knowledge must flow without the imposition of ideas, in order to facilitate the clarification of doubts, increase patient safety in the health team and characterize success in treating[2].

The basic laboratory research and evaluation complement are indicated for all hypertensive individuals, being oriented to detect clinical or sub-clinical lesions with the goal of better cardiovascular risk stratification[5]. The study pointed to user satisfaction with respect to his realization, but becomes unsatisfactory as regards the waiting time to receive the result.

The reference and counter-reference were evaluated, the first being satisfactory, and the second unsatisfactory. It is known that to ensure full care to hypertension, cardiovascular and renal risk bearer, it is necessary a standardization for tracking, even in FHBU. In some situations, there will be need for consultation specializing in health units of secondary or tertiary care, needing in such cases to establish a network of reference and counter-reference[1,13].

Table 4. Average, Standard-Deviation and Confidence Interval of socio-cultural accessibility indexes of hypertensive patients registered in Hiperdia in the period of 2006-2007, Campina Grande/PB, 2011

Variable	Average	SD	Confidence Interval (95%)	
			Min.	Max.
1. When you ask any question to the professional health unit, do you feel embarrassed?	4.58	0.875	4.49	4.67
2. Do the health unit professional answers your questions clearly?	4.57	0.835	4.49	4.66
3. Do the health professional give you enough time for you to ask questions or concerns?	4.33	1.188	4.21	4.46
4. When consulting on health unit, do the professional talk about other health problems?	3.81	1.552	3.65	3.97
5. Do the health unit professionals relate well with people in the community?	4.58	0.805	4.50	4.66
6. Have you ever thought about changing the unit because of the health professionals?	4.47	1.160	4.34	4.60
7. Do the health professional of the unit explain the examinations results?	4.17	1.383	4.02	4.31
8. Do the health unit professionals seek to meet people who live with you?	3.36	1.761	3.18	3.54
9. Do the professionals of the health unit talk with people who live with you about SAH, lifestyle, treatment and other health problems?	2.70	1.783	2.52	2.89
10. Do the health professionals talk about the importance of the involvement of your family in the treatment?	2.67	1.767	2.48	2.85
11. Do the health unit professionals talk about the importance of your participation and your family in the community institutions (churches, neighborhood association, etc.) as a support to solve your health problems?	1.73	1.383	1.59	1.88
12. How often do the health services develop actions on SAH with the Churches, Neighborhood Associations, schools, etc.?	1.57	1.154	1.45	1.70
13. Do the health unit professionals talk about the influence of family/friends/colleagues in your treatment?	2.25	1.651	2.08	2.42
14. Do the health unit professionals discuss with you on the results of the consultation on another service?	3.16	1.820	2.93	3.39
Composite index	3.42	1.090	2.79	4.05

Socio-cultural Accessibility: Satisfactory (≥ 4); Regular (≥ 3 and < 4); Unsatisfactory (< 3); SAH: Systemic Arterial Hypertension; SD: Standard-Deviation; Min.: Minimum/Max.: Maximum. Source: Study held by Paes[6].

On socio-cultural accessibility, the results are viewed positively, as there are user satisfaction when related to professional communication, and vice versa. The outcome is more favorable in the treatment when using familiar terms to the users' context. There is an opposite situation when using technical vocabularies, impacting considerably on the rise in the number of dissatisfactions with the treatment[15].

For a user-professional relationship considered good, the following attributes are required: empathy, consideration and respect, confidence in the professionals, have their questions answered and their condition is discussed and explained, have the opportunity to participate in decisions about the treatment being recommended[5].

Details of communication are small, often not valued as producers of meanings that give direction to relationships that configure links and enabling the production of care in meeting the needs and expectations of users. Thus, the cordiality becomes an important attribute in user satisfaction, being intrinsically related to the quality of user interaction and health professional and in turn on accessibility[15].

There are several determinants for non-adherence to treatment, including the users' inappropriate relationship with the team, suggesting then guidance on the benefits of treatments including lifestyle changes, as well as detailed and understandable information to patients about the possible adverse effects of prescription of medicine and needs posology adjustments over time[2].

Regarding the participation of professionals with the community obtained unsatisfactory results. This becomes worrisome, because it must be a peculiar feature of the integration between

primary care and community family health teams, seeking a trust relationship, care, respect and bond, ensuring the continuity of health actions and the longitude of care by strengthening popular participation and social control[15].

The bigger sociocultural obstacles to accessibility and thus the health education refers to the vocational training of local community contexts detached, difficulty of the teams to act in front of the singularities of the users.

Study in Brazilian Midwestern cities corroborates with the results presented, showing unsatisfactory results if the community orientation and professional involvement with the family of users[16].

In the study, there was dissatisfaction of the users regarding the role of professionals in relation to involvement with the family, opposed to the role of the FHS, which aims to meet the individual and the family of integral and continuous manner, developing actions for the promotion, protection and recovery of health. The FHS aims to promoting health with focus on the family, in their various contexts, differing in the way of caring for people centered on a biomedical model and come back only for the cure of the disease[15].

It is necessary to understand two focus: the family health, concerning the state of health of the individuals who compose it and the functioning of the family, as one evaluative description of the functions and structures of family, writing a framework where the focus of the evaluation and assistance are both on individual health, as in the health of the family as a whole[15].

It is understood here the family as the most constant health unit for its members. Thus, assistance to the family as the unit of care involves knowing how each family handles and identifies their strengths, their difficulties and their efforts to share the responsibilities and co-responsibility.

CONCLUSION

There are satisfactory results in geographical and economic accessibility, but regular results in organizational and socio-cultural accessibility, configuring a health care that ensures assistance to users with hypertension, without or with reduction of barriers, subsidizing specific programmatic actions aimed at the prevention and reduction of morbidity and mortality caused by SAH.

The findings showed ensuring the necessary care to hypertensive in the municipality of the study, aiming to obtain the efficaciousness of services SAH, having as purpose the establishment of a planning to subsidize specific programmatic actions aimed at the prevention and reduction of morbidity and mortality caused by SAH.

The study supports the proposition of measures and intervention, enabling provision of guidelines and subsidies to managers and health professionals, so that the FHS become, actually, the gateway to the health care of hypertensive patients.

This shows the possibilities of building health service alternatives together with users, for most interventions consistent with the identified problems and situations, aiming at the improvement in the daily lives of health services, providing important advances in the field of production of care and management of health services.

We have to mention the limitations of the study, recognizing that there was a set of criticisms and limitations related to data collection. One of the most frequent criticism in relation to the researchers was the subjective aspect of the categories asked to users. Another limit found was in relation to the full availability of the users to receive the researchers at all times. Several visits were made to perform data collection of some users, but in some places, the researchers had to perform nightly visits, contributing to an increase in transport costs and risk for the researchers, because in some areas, it was not advised to nocturnal visit.

Another limitation encountered was the contact with the managements of the sanitary districts to the explanation of some significant differences in them. In some answers obtained of these differences, however, in one of the managers, there was no concordance of the results, it is not possible to their explanation.

Based on the above, it is suggested to provide a satisfactory accessibility to hypertensive people, without barriers and difficulties, assuring the doctrinal principles of the Unified Health System: universality, integrality and fairness, as well as the applicability of the Reorganization Plan of Care to Arterial hypertension and *Diabetes Mellitus* in Brazil.

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