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RESEARCH

# Hypertension and Diabetes Mellitus Program evaluation on user's view

*Avaliação do Programa de Hipertensão Arterial e Diabetes Mellitus na visão dos usuários*

*Evaluación del Programa de Hipertensión Arterial y Diabetes Mellitus el la visión de los usuarios*

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**ABSTRACT**

**Objectives:** to evaluate the program proposed by the Reorganization Care Plan for Hypertension and Diabetes Mellitus on user's view, and describe aspects of the trajectory of the participants correlating with the program's evaluation. **Method:** evaluative study with a qualitative approach conducted in health units with the Family Health Strategy, in a city of the metropolitan region of Curitiba, in the period from September to March, 2012. A total of 30 adults with hypertension and/or Diabetes mellitus were interviewed. Data were analyzed through content analysis. **Results:** Four categories were identified: Disease diagnosis; Reasons for the program need; Knowledge of the program, and program evaluation. **Conclusion:** there was the recognition of the orientations, and the monitoring of activities developed, with emphasis in cost reduction for users.

**Key words:** Health Evaluation; Chronic Disease; Nursing; Adult Health; Professional Practice.

**RESUMO**

**Objetivos:** avaliar o programa proposto pelo Plano de Reorganização da Atenção à Hipertensão Arterial e ao Diabetes *Mellitus* na visão de seus usuários e descrever aspectos da trajetória dos usuários correlacionando com sua avaliação. **Método:** pesquisa avaliativa, qualitativa, realizada em Unidades com Estratégia Saúde da Família da região metropolitana de Curitiba-PR, no período de setembro a março de 2012. Foram entrevistados 30 adultos hipertensos e diabéticos. Os dados foram analisados através da análise de conteúdo. **Resultados:** foram identificadas quatro categorias: descoberta da doença; motivos da busca pelo programa; conhecimento do programa; avaliação do programa. Os usuários procuram o serviço desde a descoberta da doença e se inserem no programa, devido aos benefícios que ele proporciona para a saúde. **Conclusão:** houve o reconhecimento das orientações, do acompanhamento e das atividades desenvolvidas, com destaque para redução de custos para os usuários.

**Descritores:** Avaliação em Saúde; Doença Crônica; Enfermagem; Saúde do Adulto; Prática Profissional.

**RESUMEN**

**Objetivos:** evaluar el programa propuesto por el Plan de Reorganización de la Atención de la Hipertensión y Diabetes mellitus en vista de sus usuários; describir los aspectos de la trayectoria de los usuarios que participan en el programa junto con su evaluación. **Método**: estudio de evaluación con un enfoque cualitativo realizado en dos centros de salud de la Estrategia de Salud de la Familia, un municipio de la región metropolitana de Curitiba, en el período de septiembre a marzo de 2012. Los participantes fueron 30 adultos con hipertensión arterial y/o diabetes mellitus. **Resultados:** los datos fueron recolectados através de entrevistas semiestructuradas grabadas. El análisis resultó en las categorías: el descubrimiento de la enfermedad; razones de busca por el programa; el conocimiento; la evaluación del programa. **Conclusión:** hubo el reconocimiento de las directrices, de los seguimientos y de las actividades, con énfasis en el ahorro de costes a los usuarios.

**Palabras clave:** Evaluación de la Salud; Las Enfermedades Crónicas; Enfermería. Salud del Adulto; Práctica Profesional.

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## INTRODUCTION

Hypertension and diabetes mellitus are the leading causes of hospitalizations in the public health system and are the main risk factors for cardiovascular disease, of which about 60-80% of cases can be treated in the public primary basic care[1].

In an attempt to reduce the number of hospitalizations and achieve monitoring and appropriate treatment in primary care, various strategies and actions have been developed and adopted by the Brazilian Ministry of Health. Among these actions, we highlight the Reorganization Care Plan for Hypertension and Diabetes Mellitus (DM)[2].

The Reorganization Care Plan for Hypertension and Diabetes Mellitus uses strategies such as monthly meetings with educational actions, stimulating physical activities, scheduled doctor visits and drug delivery. Each city has a local program of activities to registered users in the hypertension and DM program[2].

Registration and monitoring of hypertension and DM patients are performed through the System of Registration and Monitoring of Hypertensive and Diabetics (HIPERDIA), established in 2002. This system generates the information for professionals and managers of Municipal, State Departments and the Brazilian Ministry of Health[1].

To achieve the improvement of the effects of the services on population health, we must pay attention to the quality of care offered[3]. To this end, we emphasize the importance of evaluation as a way to verify the conditions under which health actions are developed.

The evaluation of user satisfaction can provide elements for the adoption of new strategies or improve the existing ones to qualify the result of care. Therefore, the user can be a major contributor of the service organization if they are heard[4]. Thus, when evaluating public policies, it is possible not only to produce information aimed at improving the effectiveness of a social practice, but also to transform this practice in the light of the interests of those involved, considering their contextual relationships[5].

The relevance of this study lies on the fact that the assessment was conducted from the view of those who use the services, providing subsidies for managers in service to users. Thus, the appreciation of considerations and expectations of HIPERDIA users, the improvement in the program participation, as well as how to carry out their activities. In this sense, the objectives of this research were: to evaluate the Program proposed by the Reorganization Care Plan for Hypertension and Diabetes Mellitus on users' view and describe aspects of the trajectory of the program users correlating them with the program's evaluation.

## METHOD

This is an evaluation research with a qualitative approach. The study was conducted in the city of Colombo, Metropolitan Region of Curitiba-PR, in two health units that had the Family Health Strategy (FHS), a large unit and a small one.

The large Basic Health Unit (BHU) has four FHS teams and a population of 70 users with DM, 750 with hypertension and 321 users with DM and hypertension. The smaller Health unit has two FHS teams, 24 users with DM, 382 with hypertension and 145 with both DM and hypertension.

The inclusion criteria of the participants were adults aged 18 to 59 years, registered and active in the hypertension and DM program of the BHU. Considering the criteria of the program, the term 'active user registration' means users who go to the BHU at least once every six months to a doctor's appointment, drug delivery or participation in the meetings.

A total of 30 users participated in the research, 10 from the smaller BHU and 20 from the larger BHU, according to the sampling saturation method. In this method the researcher "closes the group when, after data collected with a number of subjects, new interviews start to present a number of repetitions in its content"[6].

Data collection was carried out on the premises of the units through semi-structured interviews recorded on audio. The quality evaluation of hypertension and DM program from the perspective of its members had questions about the process, structure and results[7], addressing the following aspects: use of the service, program knowledge, adherence to proposed activities and user evaluation.

The assessment under the use of the service was conducted through questions involving: time (in days) elapsed between the medical diagnosis of disease and the scheduling of the first doctor visit; evaluation of access to the service; user satisfaction according to the resoluteness to their problem.

Regarding the knowledge that users have over HIPERDIA and adherence to the activities proposed by the Program, questions addressing the program were: what does the user know about the program that they attend to; when and why did he/she begin to attend it and how did it happen; if they participated in the proposed activities; what are the program's contribution to their health care; what are the program difficulties; in what ways could the program improve.

The data were analyzed according to Bardin content analysis[8], which enabled the identification of four thematic categories: "Disease diagnosis", "Reasons for the program need" "Knowledge on the program" and "Program evaluation". The categories were previously delimited due to the topic of the interview, and confirmed after data analysis.

The project was evaluated and approved by the Research Ethics Committee of the Health Sciences Department of the Federal University of Parana (CAAE: 0136.0.091.000-11) after the approval of the Health Department of the City of Colombo. Resolution 196/96 of the Brazilian National Health Council[9] was followed. The Consent Form was explained to individual users who were identified as N1 to N10 in the smaller BHU, and from N11 to N30 in the larger BHU.

## RESULTS

In the first category "Disease diagnosis", 25 users revealed their health care trajectory from the time of diagnosis to the beginning of the participation in the hypertension and DM Program, as illustrated in the N10 statement:

> *I found out that I was hypertensive when I was working in a company. A blood clot Burst in my eye and I thought it was na eye problem. I went to see the ophthalmologist and he told me to look for a cardiologist because I should have been hypertensive, and that's what happened. I had health insurance so I went, I performed the effort test and all "those things" found that I had hypertension*. (N10)

The second category, "Reasons for the program need" encompasses the demand for orientation and treatment to care for health, as the statements below:

> [...] *I started participating because I was concerned about my health, my well-being* [...] *I decided to join the program as I needed treatment*. (N3)

> [...] *so that we have better monitoring, there are doctor visits, they schedule them, so it is not up to the people to go there, as they schedule we get happier*. (N16)

The drug delivery and care for health was another reason pointed out by users to need the program as N24 stated:

> [...] *Because of the drug and to attend the meeting, which is very good, we learn a lot, right? It is no use for us taking the medicine and without proper care, sometimes being careful about what we eat* [...]. (N 24)

The determining factor for the decision of using the program, according to users, was the health care team, as explained in the following statement:

> *The community health agent came home and said I had the right to participate,* [...] *then she convinced me to come. I attended the meeting, I liked it and went home! She went home twice and I said, no, I do not need, the drug is not expensive, but she said I had the right to go to the meeting* [...] *and I am going there until today*. (N22)

In the third category, the knowledge of the program was identified by its purpose and function - recognition of the orientations (learning space), disease control (monitoring) and drug delivery, according to the following statements:

> *I learned many things about hypertensive people* [...]. *This program guide us on how to proceed, they teach in every way* [...]. (N8)

> *They give us drugs and they provide lectures that help us*. (N17)

> *It is good not to have a heart attack. For not increasing the pressure* [...], *to monitor* [...]. (N27)

Knowledge of the program was identified through its operation - monthly meetings, drug delivery and scheduling doctor visits. The favorite activities of the program were the monthly meetings and the drug delivery, as shown below:

> *I always take part in the monthly meetings, I rarely miss them* [...]. *I think the meetings are interesting and enlightening, they help a lot* [...] *extending the knowledge of the people* [...]. *I think that drug delivery is excellent*. (N11)

Appointment's scheduling with doctors were reported only in the larger BHU. However, in this unit, some users said they did not have this schedule, as illustrated by the following statement:

> *The doctor visit is not scheduled, they say I am not allowed because I am not 60 years old yet. People who are 60 years are scheduled, but I will stay in line. On Monday I got in line 4 am. It's bad, but it's the way*. (N23)

Walking was reported by some users, but as separated activity and not part of the hypertension and DM Program. Five users of both units reported not knowing about walking as an indication of the health unit.

The fourth category was the program evaluation by the users, viewed as for their own benefit, as a contribution to their health, with emphasis on guidance, as shown in the discourse:

> *What helps me taking care of health is the orientation for example in food* [...] *I began to lose weight, because only the medication doesn't solve the problem, you take it and for 3 to 4 hours you are okay, then all comes back later*. (N1)

The contribution of the orientations associated with the monitoring conducted in the program was cited by some users, as follows:

> *Yes, through information and in a way through the monitoring for us to have proper care with food and a number of things* [...]. *I come because of the monitoring, not only for the drugs* [...]. (N3)

Costs reduction was cited by others as a contributing factor to the health, as exemplified in the statement below:

> *I don't think it is good or bad, but I think this drug delivery is important, because we do not always buy all the drugs,* [...]. (N4)

Program evaluation also took place with a focus on service, which involves process, structure and results. This fact could be identified on account of the difficulties of service as changing the team cited only by smaller BHU users, appointments and medication elsewhere, involving the process, as the following statements:

> *It is difficult as today they have a group, tomorrow they have another,* [...] *the person* (the professional) *comes 2-3 times and then does not come over anymore, this makes it difficult for us*. (N1)

> *The doctor visit sometimes takes time* [...] *30-40 days to schedule, each 3 months I visit the doctor to renew the prescriptions and I think it should be shorter for a better monitoring*. (N28)

> *I find it difficult to collect drug elsewhere, but at the same moment I didn't protest. I accept it. But I think they could have everything here* [...]. (N19)

Having the physical structure and medication elsewhere, which involves issues of structure, have been identified in the statements below:

> [...] *the problem is the location,* [...] *lack of space* [...]. (N13)

> *The place is not suitable, because they have a few people sitting, others standing then they have to have everything right, drugs* [...]. (N29)

The issue of tests, covering the results, was pointed out by the larger BHU users, as exemplified by the following statement:

> [...] *They have a lot of difficulties, for example, medical tests*. [...] *I went through two surgeries, I paid all these tests. If I had to wait for SUS* [...]. *And I could not afford them, so I made a loan, you know? In instalments, they accepted credit cards*. (N19)

The following suggestions for improving the program quality emerged: scheduling doctor visits, increasing the number of doctor appointments, with the same doctor, collecting food donations (volunteer service), another unit for the care of the population (larger BHU only) suitable location and concentration of all the drugs in the unit.

When asked if they would like to talk about something else for which the Program they participate, users made compliments to the health team, identified improvement in health care compared to decades ago (access), reinforcing the need for drug delivery and lectures at every meeting, more information on physical activities indicated by the team and doubts about treatment.

## DISCUSSION

The first category "Disease diagnosis" shows that the diagnosis means a milestone in the lives of many chronically ill people. The statements from N10 illustrates the moment of discovery of the diagnosis, the beginning of a ''journey' in which the chronic patient needs to take responsibility for his/her condition to initiate changes in life that are crucial to the success of disease control.

Those patients with chronic diseases experience illness in daily life, when meanings and feelings are constructed. It is in this scenario that ways to live and manage this condition are also rebuilt, permeated by a spontaneous desire to live[10]. N10's statements illustrates the need found in daily life, to seek proper treatment for the discovered disease.

The reasons for going after the program, according to N3 and N16 were monitoring, guidance and treatment for the care of their health. The bearer of chronic diseases tends to develop a set of learning strategies that allow them to live with the disease[11]. Thus, for patients with hypertension and diabetes, adherence to the program occurred as an aid for dealing with their new condition of life, as they can rely on monitoring and support of professionals.

Another reason for participating in the program was to get free medicines, which according to N24, contributes to the reduction of costs, as well as the orientation meetings held in an attempt to adhere to care and recommended treatments. The delivery of drugs, recommended by the Reorganization Care Plan for hypertension and DM program, encourages continuity of care, and in both BHUs, this activity is associated with participation in the meetings. This strategy, emphasized in the statement of N15, meets one of the objectives of the Plan, to guide and systematize prevention, detection, control and adherence of people with hypertension and diabetes in primary care[2].

For any chronic disease, the purpose of the treatment is related to control. In the case of blood pressure and glucose levels, adherence to medication and non-medication treatments are essential in order to prevent complications, comorbidities, and especially premature mortality[12].

N22 statements illustrate the importance of the health team for membership and continuity of care. This fact is mentioned in a study that underscores the regular monitoring of the patient by the family health team as an order as to the severity of the condition[13]. This statement draws attention to the right to information.

Knowledge of the program, which was the third category, was identified by its purpose and functioning. Regarding the purpose, N8`s statement shows that users recognize the program as a learning space for their health care. N17 acknowledge the importance of the orientations in addition to the delivery of medicines. Because they are multifactorial diseases, hypertension and diabetes require intervention actions such as health education which should consider individual and collective aspects[14].

User N27's statement demonstrates the importance of monitoring and treatment of the disease. Thus, it is understood that the patient should be continually encouraged to adopt healthy living habits such as proper weight maintenance, regular physical activity, suspension of smoking habit, and low consumption of saturated fats and alcohol[1].

With respect to its operation, the knowledge of program occurred through the identification of monthly meetings, drug delivery and scheduling doctor visits. All users mentioned participating in monthly meetings and drug delivery. In N11`s statement, for example, we can identify the achievement of primary prevention alongside with secondary prevention, which are advocated in the Reorganization Care Plan for hypertension and DM[2].

Health teams, especially nurses, stand out in the approach to secondary prevention, since these are the actions that are developed within the population. The attention to individuals with chronic diseases is essential to prevent complications that impair quality of life of their patients, and people living with them.

Regarding the scheduling of appointments, there were differences between the units, as there is scheduling in the larger BHU, although it is perceived and experienced in different ways among users. In the smaller BHU, scheduling appointments are not done. This difference is characterized as part of the process and, if performed in a standardized manner, could contribute to improving the user's view about the work of the staff and thus the results of health actions.

In the fourth category, users evaluated the program in relation to their own benefit and that led to the service provided

by the family health team, identifying components of the process, structure and results.

The contributions provided by users in relation to their own benefict is perceived in N1 statements with emphasis on the orientations. The stimulus to the perception that the adoption of healthy habits objective to reach a healthy lifestyle becomes essential by professionals[15], because then they can work together with users, in the achievement of this goal.

Treatment of chronic diseases involves constant vigilance and monitoring for compliance and possible minimization of the appearance of complications[16]. The measurement of blood pressure and blood glucose were monitored separately, and the disease monitoring control demonstrates the attention that users need for the perception of the team care about their health. In the health assessment, these factors are part of the process.

Regarding cost reduction due to the drugs delivery evaluated by users, N4 statement included Ordinance/GM/MS No. 371 of 04/03/02 established by the National Program of Pharmaceutical Assistance for Hypertension and Diabetes Mellitus[2].

The drug delivery is considered unique cause for the participation of some users to HIPERDIA Program. However, the linking strategy of participation in the meeting due to this activity ends up being a way that the health team met to try to capture and encourage changes in lifestyle of patients with hypertension and DM.

With the performance of this activity we seek the perception, on the part of users, from the importance of the orientations associated with the drug delivery in the Program because the drug treatment if exclusive, will not reach the appropriate blood pressure and glycemic indexes in most cases. These two measures, taken together, constitute the process associated with the health service structure, evaluated by users.

Regarding the evaluation of users with a focus on service, there were differences between the larger and smaller BHU. The difficulty reported in both units was to schedule doctor visits. In the smaller BHU doctor visits are not scheduled and in the larger BHU doctor visits are scheduled. However, these doctor visits are experienced differently by users, as it is explicit in N28 statements, and as already noted in the third category referring to knowledge of the program. Therefore, the appointments do not occur in the same way for everyone. This activity is part of the process in the qualitative evaluation.

The constant change in staff was a difficulty perceived by smaller BHU users, as showed in the N1 statement. The FHS intends to highlight experiences focusing on improving the quality and humanization of care that require new conceptions of services, expressed in caring and bonding[17]. So the constant change of health team can hamper the establishment of bond between population and health service, and the establishment of trust for successful treatment.

The structure and the results were evaluated in the difficulties of physical space, drugs and tests by health users as factors that hinder monitoring and health care access to the service.

A previous study identified difficulties to make appointments with specialists, diagnostic and therapeutic support services, in medium and high complexity of care, long waits, lines, and delays in receiving tests results, among others. In the pursuit of integrality of care, it faces the implementation of the family health team, this situation has received strong criticism from professionals and especially of users as the main harmed by this system operation[18]. A similar result was found in the present study.

In line with the difficulties encountered by users, suggestions for improving the program emerged, as stated in the results. They listed suggestions that make up the process, the structure and the results under the qualitative evaluation. Requests reported by users are called for in the Reorganization Care Plan for hypertension and DM, as well as the FHS orientations, which determine the creation of bond with the population, monitoring of risk groups and use of resources to meet the population needs[2].

Considering the access of health services addressed in the statements of users, similar results have been reported in relation to appointments in the unit and referrals, as users cited there is a great demand for care[18].

Users suggested improvement in service and care as observed in the statements relating to difficulties and suggestions to the program. In a previous study, the factors referred to improve the service were: structure (21.8%); service (14.6%), increasing the number of appointments; having the drug available in the unit, and maintaining regular supply of drugs, etc. [19]. These factors were also cited in another study[3], being contemplated in the results of the current research.

Regarding the compliments for the health team, previous research supports the current data with regard to the positive reviews of users, among which we highlight: the proper care (social contact) of the team; quality; educational actions and problem solving[18].

Although users do not have knowledge of the guidelines of the Reorganization Care Plan for hypertension and DM[2], the evaluation made by them emerged aspects contained in these guidelines. The existence of a satisfactory professional-user relationship and recognized by FHS users can demonstrate accountability to the population. It is this relationship of respect, understanding and listening that makes the difference between the practices of health actions. With the politicization of users, we can reach a service focused on meeting their needs and the manager's awareness of their obligations, to provide dignified and the best quality of care[3].

This research has the limitation of data collection because of the interviews conducted within health units, possibly influencing the criticism of users to a service on which they depend on. However, despite the reports of difficulties and suggestions, they were concerned about providing compliments to the service and care.

Thus, it was found that there is need for effective implementation of the Family Health Strategy, improvement in the physical structure of the service and standardization of the process of care. Thus, qualitative health evaluation helped us to identify problems that often cause differences in interest between those performing them (professionals) and among those who experience them (users).

Therefore, new evaluation studies should be developed involving various participants, users, professionals, managers and community in general so that different views can support the improvement of quality of care.

## FINAL CONSIDERATIONS

The evaluation performed demonstrates the perception of users about the contribution of the hypertension and DM Program for the care of their health, regardless of the illness trajectory. Knowledge of the diagnosis was the starting point for the program demand, with emphasis on the reduction of costs for buying drugs. Aspects relating to the physical structure and appointments with specialists were points highlighted by the users as well as the lack of standardization of care. This research enabled us to identify the challenges to overcome qualitative health evaluation for effecting improvements in care practice.

The manuscript deals with a major issue for SUS, health professionals and the general population, in the perspective of better knowing this problem and trying to decrease complications. For this to happen concentrated effort from sick people, professionals and managers at different levels of health care in the country is required.

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