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ORIGINAL ARTICLE

QUALITY OF LIFE OF PEOPLE WITH ARTERIAL HYPERTENSION

QUALIDADE DE VIDA DE PESSOAS COM HIPERTENSÃO ARTERIAL

LA CALIDAD DE VIDA DE LAS PERSONAS CON HIPERTENSIÓN ARTERIAL

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ABSTRACT

Objective: to evaluate the quality of life of people with hypertension and relate it to sex and the pressure value. ***Method:*** this is a quantitative, descriptive, cross-sectional study with 191 people under treatment of hypertension attended by the Family Health Strategy. The data were collected using the tool MINICHAL - Brazil and the Medical Outcomes Study 36 - Item Short - Form Health Survey and questionnaire was applied to the knowledge of demographic profiles, economic and life style. Descriptive analysis and inferential statistics for the treatment of variables. The results are presented in the form of tables. ***Results:*** reveals that the majority of the interviewees was elderly, with low schooling, married and belonged to economic class AB extract. Presented themselves, regarding the assessment of quality of life, the interviewees males better evaluation in all dimensions analyzed in comparison with the female population. It has been shown that, by the majority of subjects with adequacy in blood pressure control, good quality of life, and being that the mental state, the somatic manifestations, the general state of health, functional capacity and physical performance had significant differences. ***Conclusion:*** it was observed, with the use of the tools mentioned above, that the majority of the interviewees presented a good quality of life. ***Descriptors:*** Hypertension; Quality of Life; Family Health Strategy; Adult Health; Nursing; Public Health.

RESUMO

***Objetivo*:** avaliar a qualidade de vida de pessoas com hipertensão arterial e relacioná-la ao sexo e ao valor pressórico. ***Método*:** trata-se de estudo quantitativo, descritivo, transversal, com 191 pessoas em tratamento da hipertensão arterial acompanhadas pela Estratégia Saúde da Família. Coletaram-se os dados com o MINICHAL – Brasil e o *Medical Outcomes Study* 36 – *Item Short* – *Form Health Survey* e se aplicou questionário para o conhecimento dos perfis sociodemográfico, econômico e estilo de vida. Realizou-se análise descritiva e inferencial para o tratamento das variáveis. Apresentaram-se os resultados em tabelas. ***Resultados*:** revela-se que a maioria dos entrevistados era idosa, com baixa escolaridade, casada e pertencia à classe econômica extrato AB. Apresentaram-se, quanto à avaliação da qualidade de vida, os entrevistados do sexo masculino melhor avaliação em todas as dimensões analisadas em comparação com a população feminina. Mostrou-se, pela maioria dos sujeitos com adequação no controle pressórico, boa qualidade de vida, sendo que o estado mental, as manifestações somáticas, o estado de saúde geral, a capacidade funcional e o desempenho físico tiveram diferenças significativas. ***Conclusão*:** observou-se que a maioria dos entrevistados apresentou boa qualidade de vida. ***Descritores*:** Hipertensão; Qualidade de Vida; Estratégia Saúde da Família; Saúde do Adulto; Enfermagem; Saúde Pública.

RESUMEN

Objetivo: evaluar la calidad de vida de personas con hipertensión y relacionarlo con el sexo y el grado de la presión. ***Método:*** se trata de un estudio cuantitativo, descriptivo de corte transversal, con 191 personas bajo el tratamiento de la hipertensión arterial acompañadas en la Estrategia Salud de la Familia. Los datos fueron obtenidos mediante el instrumento MINICHAL - Brasil y el estudio de resultados médicos 36 - Ítem Short Form Health Survey y el cuestionario fue aplicado para el conocimiento de perfiles demográficos, económicos y de estilo de vida. Análisis descriptivo e inferencial estadística para el tratamiento de variables. Los resultados se presentaron en forma de tablas. ***Resultados:*** revela que la mayoría de los entrevistados era anciana, con baja escolaridad, casada y pertenecía a la clase económica AB extracto. Se presentaron, en cuanto a la evaluación de la calidad de vida, y los hombres entrevistados una mejor evaluación en todas las dimensiones analizadas, en comparación con la población femenina. Se ha demostrado que, en la mayoría de los sujetos con suficiencia en el control de la presión arterial, la buena calidad de vida, siendo que el estado mental, las manifestaciones somáticas, el estado general de salud, la capacidad funcional y el rendimiento físico había diferencias significativas. ***Conclusión:*** se observó, con el uso de las herramientas mencionadas anteriormente, que la mayoría de los entrevistados presentan una buena calidad de vida. ***Descriptores*:** Hipertensión; Calidad de Vida; Estrategia de Salud Familiar; Salud del Adulto; Enfermería; Salud Pública.

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INTRODUCTION

It is known that arterial hypertension (AH) is a chronic disease characterized by a multifactorial condition that presents high levels of pressure in the walls of blood vessels. It helps, for some factors, such as overweight, obesity, sedentary lifestyle, aging, inadequate diet, the abusive use of alcoholic drinks, the stress and genetic factors, for triggering such morbidity.[1-2] It is the high incidence of complications and mortality caused by the disease as a public health problem worldwide[1-3] and, according to the World Health Organization (WHO), more than one billion people in the world has AH, being more affected the population of low- and middle-income countries.[3]

Please note that, in the American continent, about 250 million people suffer from high blood pressure, and each year, about 1.6 million deaths are caused by cardiovascular diseases, of which half a million occurs in individuals aged less than 70 years old.[4] It has, in Brazil, the incidence of hypertension in approximately 60% of the elderly population, representing more than 50% of the causes of deaths among cardiovascular diseases.[5] It is observed, in this scenario, the need of health education actions to promote the prevention of habits of risk, treatment and blood pressure value of this morbidity.[1]

Has become, for both, the health professional from the team of the Family Health Strategy (FHS) important role, since, through the establishment of a relationship of bond with the user, it is possible to construct interventional projects closer to the needs of individuals, allowing a better adherence to treatment and, consequently, obtaining more meaningful results regarding treatment of this disease aggravating factor.[6]

It drives, so the changes produced after his diagnosis, a quality of life that, many times, may not be satisfactory for the person with AH, and psychosocial damage, financial and even spiritual.[7] Defines the quality of life (QoL), by the WHO,[8] as the individual perceives its participation in the contexts of culture and systems of social values in relation to which he possesses as expectations, standards and concerns.

It is understood, in this aspect, together with the stressing changes by which people with AH are affected, such as the difficulty of adaptation and mechanisms to cope with the disease, difficulties in following the treatment appropriately, changes in lifestyle and food, that the QoL tends to be affected. It allows, in this way, to assess the impact of the disease and its evolution from the time of diagnosis, better acquainted with the individual and their actions to adapt to the disease, having in view the socioeconomic factors, clinical and psychosocial problems that are potentially modifiable, and also provides the identification of new social and health indicators, favoring a humanized and recognizing the importance of satisfaction and well-being own of these people.[9]

It provides that, in this way, the assessment of QoL in people with AH, the understanding of important determinants in promoting a more adequate treatment, therefore, the accession to it, and may be an indicator to subsidize the clinical trials of specific diseases and to assess the physical and psychosocial impact that generate in people who fall ill, allowing a better knowledge about their health condition.[7]

OBJECTIVE

- To assess the quality of life of people with hypertension and relate it to sex and the pressure value.

METHOD

It is a quantitative, descriptive, cross-sectional study with 191 people in the treatment of hypertension, accompanied by the FHS in the municipality of Maringá, located in the northwestern part of the State of Parana, Brazil. It is known that the municipality has 35 Basic Health Units (UBS) in operation and 75 teams of the FHS, total population coverage of 68.01%, and are indexed, until the year 2016, about 29,035 people with the morbidity in HIPERDIA program.[10]

It explains that the HIPERDIA program is a system of registration and monitoring of people with Hypertension and Diabetes Mellitus (DM) indexed in the Information System of Basic Care (SIAB). Enables, through this program, the knowledge of the epidemiological profile of registered patients, generating information for local managers and secretaries of state and municipal health, as well as for the Ministry of Health.[11]

It is delimited as inclusion criteria of the study, adults older than 18, residing in the urban area of the municipality, registered in the HIPERDIA and which, at the time of data collection, had received treatment for health care professional of BHU over the past six months prior to data collection. Pregnant women were excluded during the data collection period.

The sample was stratified per unit, five BHU being selected in accordance with the release of the Municipal Secretariat of Health. Arose a random sample and for the sample size calculation was used as a basis, the total population of 6,519 users with AH, which was based on the sum of individuals of five units selected and from this list. There was a representative sample, calculated by means of a process of simple, with stratified sampling error of estimate of 5% and 95% confidence interval.

The sample was constituted by 172 people, plus over 10% for possible losses, totaling a final sample of 191 people. Held after the sample calculation, the stratified sample of users with AH registered in each BHU included in the survey, from the list provided by the Municipal Health Secretariat, with name and code of the address on the internal network system of health care, and the draw as the number of people answered in each unit. Asked, when the individuals selected did not meet the inclusion criteria or refused to participate in the study, automatically, the next on the list to participate in the study.

It presents, in table 1, the total number of people with AH indexed in five randomly selected BHU.

Table 1. Stratified sampling of individuals with hypertension served by primary health care. Maringá (PR), Brazil, 2017.

BHU	Total of assisted	Sample
BHU 1	1.673	48
BHU 2	932	27
BHU 3	1.243	36
BHU 4	2.098	61
BHU 5	603	19
Total	**6.519**	**191**

Held to start the data collection, the contact with the managers, doctors and nurses of the BHU, which delivered the researchers for the study participants at the time of the meetings of the HIPERDIA, when they were presented the objectives and how they would collect data and performed the invitation to participate. The data were collected by means of the application of the questionnaires between the months of February to March 2017.

It was used four separate instruments: the first, built by the researchers, aimed to raise the sociodemographic profile and the style of life, questioning about the use of tobacco, alcohol consumption, physical activity practices, supply type specific to the matter ingestion of fat and salt. Held, then the pilot test, which was subjected to modifications to the qualification and suitability to the context in which it is applied.

It was evaluated and ranked in the second, the population regarding economic level, in that one used the instrument the Brazilian Economic Classification Criteria, which has the objective of estimating the purchasing power of people and urban families.[12] Contain, in the instrument, questions relating to the possession of certain consumer goods, schooling of the head of the family and public services (piped water and paved street). It presents, in the end, a cut-off point and classification A, B1 and B2, C1 and C2 and DE. Grouped themselves, in this study, the classification in AB, C, and DE.

It has been the Medical Outcomes Study 36 - Item Short - Form Health Survey (SF-36) as an instrument that has already been validated in Brazil and has several items that measure the quality of life, being used in clinical research and population surveys. It turns out that it is composed by eight multidimensional scales, has 11 questions and 36 items, represented by functional capacity (10 items), physical aspects (4 items), pain (2 items), overall health status (5 items), vitality (4 items), social aspects (2 items), emotional aspects (3 items), mental health (5 items), and a comparative question about the current perception of health and a year ago. Receives, by the individual, a score in each domain, which varies from zero to 100, where zero is the worst score and 100 the best.[13]

It is clarified that the specific questionnaire to assess quality of life of the person with AH is the MINICHAL, being the most used and known for its easy application. It was found that it has its original version in Spanish and has already been translated and adapted cross-culturally to Brazil (MINICHAL-BRAZIL), is composed by 17 questions and divided in two areas characterized by the current mental situation and by somatic manifestations caused by AH. Attributed to the answers in the domains to a frequency range of the Likert type with four options of

answers from zero (No, absolutely) to three (Yes, very much).[14]

It describes that, on this scale, the closer to zero was the result, the better the QoL. Understand yourself, by the Mental Status domain, the questions from one to nine, being the maximum score of 27 points. Cover yourself, by field Somatic Manifestations, questions 10 to 16, with a maximum score of 21 points, and the latest issue has as objective to verify how the patient evaluates that hypertension and its treatment have influenced their QoL. Present themselves, in the Brazilian version, a reliability alpha of 0.88 for the Mental Status domain and reliability alpha of 0.86 for the Somatic Manifestations domain[14]. Become the matters of mental status and Somatic Manifestations of MINICHAL, for which the higher scores represent a better QoL.[14]

If the teams were informed in advance that the data referring to blood pressure values would be required for the research. It is inferred that, as part of the routine of health professionals performing the collection of such data during the meetings of HIPERDIA, researchers decided to use these data collected not to cause the exhaustion of the interviewees to perform the entire procedure again. Made available, then, at the end of the interviews of each period, by a nurse or Nursing, these data are essential for the completion of the form.

It codified values in blood pressure value appropriate and inappropriate pressure value, in that if deemed appropriate value when the values of systolic arterial pressure (SAP) were ≤ 140 mmHg and diastolic blood pressure (DBP) ≤ 90 mmHg, whereas the criteria of the VII Brazilian Guideline of hypertension.[15]

We used the Kolmogorov-Smirnov and Shapiro-Wilk tests to verify the data distribution, whereas it was not normal. Submitted to descriptive analysis by means of tables, with frequency distribution and descriptive measures such as mean and standard deviation. Checked all the questionnaires, tabulating them in a spreadsheet and, subsequently, the data were analyzed by means of the software IBM SPSS, version 20.0. It was used for the analysis of association between the issues of MINICHAL, SF - 36, sex and blood pressure value, the Mann-Whitney test, whereas the value of $p < 0.05$ as significant between the tests performed.

This was followed by research, the precepts of the resolution 466/2012[16] and it was appreciated by the Standing Committee on Ethics in Research with Human Beings, receiving favorable opinion (protocol N 1,407.687/2016). It is signed by all the interviewees, the Informed Consent Form (ICF) in two ways.

RESULTS

Interviewed 191 people with AH, as shown in table 2.

Table 2. Sociodemographic profile of people with hypertension assisted by the family health strategy. Maringá (PR), Brazil, 2017.

Variables	Total (N = 191)		Female (N = 129)		Male (N = 62)	
	N	%	N	%	N	%
Age						
30 – 39	6	3,1	5	3,9	1	1,6
40 – 49	7	3,7	6	4,7	1	1,6
50 – 59	27	14,1	21	16,3	6	9,7
> 60	151	79,1	97	75,2	54	87,1
Years of study						
Not literate	26	13,6	18	14,0	8	12,9
1 a 4	92	48,2	60	46,5	32	51,6
5 a 8	41	21,5	29	22,5	12	19,4
< 9	32	16,8	22	17,1	10	16,1
Marital Status						
Single	8	4,2	6	4,7	2	3,2
Married	130	68,1	76	59,8	54	87,1
Separated/Div orced	13	6,8	10	7,8	3	4,8
A widower	40	20,9	37	28,7	3	4,8
ABEP						
AB	90	47,1	63	48,9	27	43,5
C	88	46,1	57	44,2	31	60,5
DE	13	6,8	9	6,9	4	6,5

It has been reported, for the variables of interest for table 3 lifestyle.

Table 3. Lifestyle of people with hypertension assisted by the family health strategy. Maringá (PR), Brazil, 2017.

Variables	Total (N = 191)		Female (N = 129)		Male (N = 62)	
	N	%	N	%	N	%
Smoker						
Yes	19	9,9	11	8,5	8	12,9
No	145	75,9	104	80,6	41	66,1
Already smoked	27	14,1	14	10,9	13	21
Alcohol consumption						
Daily	7	3,7	3	2,3	4	6,5
1 - 2 times	11	5,8	5	3,9	6	9,7
3 - 6 times	5	2,6	3	2,3	2	3,2
Never drunk	143	74,9	108	83,7	35	56,5
Eventually	25	13,1	10	7,8	15	24,2
Pressure Value						
Suitable	146	76,4	102	79,1	44	71
Not suitable	45	23,6	27	20,9	18	29
Physical Activity						
Yes	136	71,2	92	71,3	44	71
No	55	28,8	37	28,7	18	29
Diet						
Low-Calorie Diet	75	39,5	53	41,3	22	36,3
Salt restriction	116	60,5	76	58,7	40	63,7

It was evidenced, related to quality of life, which, in accordance with the instrument MINICHAL, the general condition presented the highest average with 70.96±11.26, which can be interpreted as a good quality of life; however, the somatic manifestations were statistically significant when compared to the difference between the gender of the interviewees, and the male patients had a higher average in all dimensions assessed in comparison to the female population (Table 3).

Shown, in Table 3, also, the averages and the standard deviation of the results of the scores assessed using the SF-36 tool.

Table 4. Quality of life of people with hypertension assisted by the family health strategy according to sex. Maringá (PR), Brazil, 2017.

Variables	Total (N = 191)	Female (N = 129) A±SD**	Male (N = 62) A±SD**	P A±SD*
MINICHAL				
Mental State	62,18±11,50	60,80±14,41	65,05±13,08	0,051
Somatic Manifestations	62,39±12,06	60,60±12,46	66,12±10,30	0,003*
General	68,97±14,15	68,02±15,30	70,96±11,26	0,179
SF – 36				
Functional Capacity	79,71±26,55	77,82±26,37	83,62±26,72	0,158
Physical Performance	78,66±39,97	76,55±40,23	83,06±36,15	0,281
Pain	68,82±23,25	67,49±23,84	71,58±21,91	0,257
General health status	76,92±21,11	74,08±22,02	82,83±17,89	0,007*
Vitality	65,60±15,87	63,33±16,63	70,32±13,05	0,004*
Social Aspects	66,95±22,13	64,43±22,28	72,17±21,04	0,023*
Emotional Aspect	68,66±32,49	85,01±34,09	90,16±28,76	0,254
Mental Health	67,53±21,01	64,86±20,98	73,09±20,08	0,011*

**A: Average; SD: Standard Deviation. *: P < 0.05.

Pointed out, the SF-36 questionnaire, also, that patients with adequate pressure value presented better average in all dimensions assessed. Were the dimensions of functional capacity, physical performance and general state of health were statistically significant, showing that people with adequate blood pressure control have a better quality of life in the dimensions mentioned (Table 4).

Table 5. Quality of life of people with hypertension assisted by the family health strategy in line pressure value. Maringá (PR), Brazil, 2017.

	Total (N = 191) A±SD**	Pressure Value** Suitable (N = 146)	Not suitable (N = 45)	*P*
MINICHAL				
Mental State	62,18±11,50	63,71±12,99	57,22±16,41	0,007*
Somatic Manifestations	62,39±12,06	63,67±11,52	58,25±12,96	0,008*
General	68,97±14,15	70,54±12,69	63,88±17,31	0,006*
SF – 36				
Functional Capacity	79,71±26,55	82,60±24,48	70,33±30,84	0,006*
Physical Performance	78,66±39,97	84,24±34,61	60,55±46,61	0,000*
Pain	68,82±23,25	69,53±23,01	66,51±24,15	0,417
General health status	76,92±21,11	79,27±19,57	69,31±24,17	0,005*
Vitality	65,60±15,87	66,43±16,07	62,88±15,05	0,190
Social Aspects	66,95±22,13	67,22±23,73	66,86±21,70	0,925
Emotional Aspect	68,66±32,49	88,73±30,23	80,01±38,53	0,115
Mental Health	67,53±21,01	69,04±20,20	62,66±22,97	0,075

**A: Average; SD: Standard Deviation. *: P < 0.05.

DISCUSSION

Indicates the quality of life, the level of basic and supplementary conditions of an individual, and such conditions involve several factors, these being emotional, social, religious, related to beliefs, psychological and physical status, and relationship with the environment in which they live. It is perceived that quality of life is influenced by several factors, explaining the complexity and subjectivity of the concept.[1]

It was identified, in this research, the majority of participants was elderly, being confirmed this prevalence in several other studies;[1-2,17] In addition to the elderly (79.1%), the majority of the population was female (67.5%), which, in the understanding of the researchers, results in two aspects: The first is that, for men, there is an increase in blood pressure until 50 years old, and already in women, this increase is intensifying due to the period of climacteric and menopause, i.e., after 50 years old, and this fact happens due to hormonal changes, which weakens the woman and directly influences your cardiovascular health.[18]

It stands out another aspect pointing out that women are more careful with health, because, in a general way, there are more women in HIPERDIA program and in the BHU to take care of health compared to men. It is understood that they are more concerned in controlling diseases and preventing their grievances, since the male tends not to seek, with frequency, the health system to have difficulty to exert a preventive behavior, many times, for shame and insecurity, but also due to the hours of operation are not compatible with the availability of patients. It is believed that this situation affects men to seek the health system only when you already have symptoms or aggravating problems, because, most of the times, the AH is

asymptomatic of initiation and, with time, can bring serious complications for the individual's health.[19]

It should be noted, with respect to schooling, that the majority had up to four years of study. It is understood that, in the age of 50, the times of studies were substituted for the dedication to work, usually in agriculture and trade to help support the house and the whole family, so children are not completed basic education, reflecting, in actuality, in an expressive percentage of elderly population with low schooling. It is difficult, for that matter, also, the understanding of the disease and the continuity of the treatment.[6]

It appears that the majority were married, considering the marital status of the study population, and people with companions have greater ease in dealing with the process of disease due to significant support and routine that receive.20 It is inferred, in this aspect, there is greater incentive when it has a companion to keep in constant treatment with discipline and meet the requirements proposed for a better quality of life and well-being, because if note that one helps the other to maintain a healthy life.

It stands out, when treating of the domain social class, that the prevalence was of extract AB, and have a greater economic power and live in areas with good housing conditions shall cooperate to ensure that the individual has a greater adherence to treatment and life habits more healthy. It is possible, however, that persons of low economic classes have higher chances of developing diseases, often related to poor nutrition, poor environmental conditions of housing, as access to drinking water and sanitation, as well as the conditions of work and existence.[21]

Details, in what refers to the style of life of patients treated in the FHS, in a general way, that they have a relatively healthy life style, having in view that the majority don't smoke (75.9%) and does not consume alcoholic beverages daily (74.9%), what can encourage the proper value of blood pressure and reducing the chances of complications and comorbidities, especially on the question of consumption of alcoholic beverages, which interferes with the adherence to treatment and have interactions with the medications used for the treatment of choice.[1]

We need, however, that the health teams to carry out activities that encourage self-care practices, especially those that relate to smoking. It is necessary, as the majority of the population has a low educational level, that education in health is present, mainly during the HIPERDIA meetings that result in benefits for people with AH, improving their quality of life and strengthening the treatment of the disease.[1,17]

You mentioned, in this aspect, the majority of respondents, practicing physical activity, regarded as one of the factors that decrease the likelihood of aggravating factors due to the improvement of physical conditioning. It is, in this sense, of great importance that the health team encourages users to make physical activity, since obesity is a risk factor for hypertension. Consumes, with physical exercise, by the patient, more water, controlling your weight, improving the mental health and reflecting on the quality of life.[22]

It was stated by the participants of this research, try to maintain a healthy diet to the extent possible, consuming a low-calorie diet and with salt restriction, which minimizes the negative impacts caused by the aggravation of the disease. It should be emphasized that the supply is directly related to the quality of life, health, and the consumption of fruits, vegetables, legumes, carbohydrate and protein in a balanced way, causes the body to react positively to the treatment. It is pointed, in some studies,[23-25] the difficulty of patients' adherence to a healthy diet by reason to drastically change the habits of the person with HA. Stresses that the excessive consumption of salt causes blood pressure increase, making its maintenance and treatment to prevent aggravation of the disease.[26]

It is employed for the evaluation of quality of life, two instruments: The Minichal, which is specific to the person with there, and the SF-36. Embrace, by the instrument MINICHAL, mental state, the somatic manifestations and mental health in general. It was evidenced, with relation to the mental state, similarity in comparison with the study conducted in Minas Gerais [24] with people in treatment of hypertension; however, this study was still a best result of the quality of life of individuals with the disease.

It was observed, although some studies[1,24] have shown that people with AH have a worse quality of life, in this study, the population participant has good quality of life, presenting better results than those found in other studies.[23-4] Promote yourself, by health services, in particular the FHS, despite some difficulties, actions and services that promote the bond, which contributes to the adherence to treatment and for the adoption of the suggestions of habits of life proposed by health professionals.[27]

It was obtained, in this study, the male population, a higher average in relation to mental health and their somatic manifestations in comparison with women, indicating that men are with relatively good quality of life. We corroborate this result, a study conducted with people in the treatment of hypertension in Rio de Janeiro.[23] You will notice that the male population is less prone to have difficulties in relation to the psychological and emotional aspects; since the women express more difficulties and this is due to low production of serotonin and fluctuation of hormones, making them more susceptible to a mental status and Somatic Manifestations with low scores, reflecting directly on their quality of life.[24]

Pointed out, the SF-36 instrument, satisfactory values in relation to the quality of life of patients residing in Maringá and who are being assisted by BHU. It was obtained, with relation to the SF-36 instrument in comparison with another study,[28] carried out in Guarapuava-PR, who used the same instrument, a quality of life with a little smaller than the resident population in the municipality, in all the issues raised, such as, for example, the functional capacity in which the result was 74.07±18.710; already in this study was the average of 79.71±26.55; however, even with this small difference in values presented, both cities have good quality of life, according to the interviewees. It follows that, in this study28 in discussion, men also obtained a score higher than women, in relation to all the dimensions analyzed.

Presented in a study conducted in the city of Jequié, Bahia, results similar to this study, pointing to the chronicity of disease as a major factor in the lower scores related to the dimensions of quality of life. Relates to the chronicity of the time living with the disease and the results from the treatment, to maintain adequate blood pressure control. It stands out, in this way, the importance of this study to point out such results and promote the need for new strategies for coping with the disease.[29]

It is evident, in addition to the issues related to biological factors, that the social and psychosocial issues are comprehensive and have an influence on quality of life, and should be considered in the therapeutic plan of people with AH. You can encourage, to preserve relationships, social interaction, especially with family and friends, as well as the religious apparatus, the quality of life, enhancing positive responses to treatment of the disease.[30]

Indicate whether, in matters relating to the vitality, functional capacity and physical performance, which showed statistically significant differences, good quality of life for those who had adequate pressure value and the need for more intensive treatment, mainly by the population be elderly, which certainly has an impact on the physical performance of these patients intensified by the disease. It is noteworthy that the functional autonomy can influence the social and emotional aspects, being necessary public policies for the issues under discussion.[30]

Allowed to demonstrate that, in general, the interviewees accompanied by the FHS have a good quality of life, in which were analyzed the social aspects, emotional, physical and psychological, with adequate blood pressure control. It is evident that, in this study, the interviewees have good food, with minimum consumption of sodium and fat and practice of physical exercise, encouraged by health professionals.

It is believed that the continuation of the study, with the aim of identifying potential gaps that interfere in a more effective assistance, will make possible the organization, management and implementation of the actions that are already carried out and, consequently, improve the quality of life of the participants of the study. This study is limited to the geographical issues, for having been held in a city and with only five BHU, whereas the city has 35, which does not accredits the generalization of these data with the entire population with AH accompanied by the municipality.

CONCLUSION

We found that patients of Five Basic Health Units in the municipality, the setting of this study, have good quality of life. It was identified that the female population had a higher percentage of non-smokers, have never consumed alcohol, performs practice of physical activities, has a low-calorie diet and has adequate pressure value, while the male population had a higher prevalence in relation to the restriction of salt. It has also been observed that, despite the fact that women have better style of life, men have a better quality of life in all dimensions analyzed.

It was examined whether, in accordance with the MINICHAL, that there were significant differences in the Somatic Manifestations, when considered sex as a dependent variable, being that the male population has a better quality of life and the pressure value, the same instrument presented significant

differences between mental health, the somatic manifestations and the general state of health in which people with blood pressure control appropriate to have a better quality of life.

We conclude that, in relation to the SF-36 instrument, that the general state of health, vitality, social aspects, and mental health showed significant differences when related to sex in the female population has a better quality of life, and about the value of blood pressure, there was a significant difference in the functional capacity, physical performance and general state of health, considered as good quality of life for the population which has adequate pressure value.

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