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Therapeutic itineraries of migrant women with arterial hypertension: views from the health-disease-care process

Itinerarios terapéuticos de mujeres migrantes con hipertensión arterial: miradas desde el proceso salud-enfermedad-atención

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ABSTRACT:

Introduction: Arterial hypertension (AH) is a global risk factor for morbidity and mortality and the main cause of premature death, largely affecting women. The purpose of the study was to understand how migrant women (MW) with AH configure their therapeutic itineraries (TI) in the search for health care in Colombia, from the health-disease-care process.
Methods: Qualitative study with a grounded theory approach. 16 interviews and two focus groups were conducted with MW with AH in Popayán Colombia. Intentional theoretical sampling was carried out until reaching theoretical saturation and the abstraction of emerging categories through open, axial and selective coding.
Results: Open coding generated 1,135 codes. The main emerging category was that TI in AH care are determined by social, cultural, political, and economic dynamics. As related subcategories emerged: the risks of getting sick from AH configure TI; heterogeneity of formal and informal therapeutic resources arises to attend to the disease; there are determinants of access to the health system; and mobilization of various practices for monitoring and control of the disease.
Conclusion: Women in a situation of migration with AH configure TI to achieve health care not only from the state health system, but from various elements of the social, cultural, political and economic order. To this extent, AH goes beyond morbid nominations exclusive to biomedicine and the doctor-patient relationship, to address and transcend towards a condition that requires resolving contingencies of the context.

Keywords: Therapeutic itineraries, health/illness/care process; Arterial hypertension; Woman; Migrant.

RESUMEN:

Introducción: La hipertensión arterial (HTA) es un factor de riesgo de morbilidad y mortalidad a nivel global y la principal causa de muerte prematura, afecta en buena parte a mujeres. El propósito del estudio fue comprender cómo las mujeres migrantes (MM) con HTA configuran sus itinerarios terapéuticos (IT) en la búsqueda de atención sanitaria en Colombia, desde el proceso salud-enfermedad-atención.

Métodos: Estudio cualitativo con enfoque de teoría fundamentada. Se realizaron 16 entrevistas y 2 grupos focales a MM con HTA en Popayán Colombia. Se realizó muestreo teórico intencionado hasta alcanzar la saturación teórica y la abstracción de categorías emergentes a través de codificación abierta, axial y selectiva.
Resultados: La codificación abierta generó 1.135 códigos. La categoría principal emergente fue que los IT en la atención de la HTA están determinados por dinámicas sociales, culturales, políticas y económicas. Como subcategorías relacionadas emergieron: riesgos de enfermar por HTA configuran IT; surge heterogeneidad de recursos terapéuticos formales e informales para atender la enfermedad; existen determinantes de acceso al sistema sanitario; y movilización de diversas prácticas para el seguimiento y control del padecimiento.
Conclusión: Las mujeres en situación de migración con HTA configuran IT para lograr la atención en salud no solo desde el sistema sanitario estatal, sino a partir de diversos elementos del orden social, cultural, político y económico. En esta medida, la HTA supera nominaciones mórbidas exclusivas de la biomedicina y de la relación médico-paciente, para abocarse y trascender hacia un padecimiento que exige resolver contingencias del contexto.

Palabras clave: Itinerarios terapéuticos; proceso salud/enfermedad/atención; Hipertensión arterial; Mujer; Migrante.

INTRODUCTION

Arterial hypertension (AH) is a morbid condition, defined as the persistent elevation of the force or pressure with which blood flows through the arteries, making it one of the main public health problems due to the global burden of morbidity and mortality it generates, responsible for about 10 million deaths and 200 million disability-adjusted life years lost (1). It is considered the leading cause of premature death, affecting 1.13 billion people, two-thirds of whom belong to low- and middle-income countries (2).

In Colombia, the prevalence of prehypertension and hypertension has been estimated at 62% in adults (3). The CARMELA study showed that at early ages, it is more prevalent in men; however, as age increases, this rate is inverted, becoming more prevalent in women (4). A study that followed 33,000 people for 40 years showed that women had a more pronounced elevation of blood pressure (5), experiencing a 25% increase in the risk of cardiovascular disease, and men a 15% increase.

One risk for AH is the process of internal migration due to forced displacement, defined as 'persons or groups of persons forced to flee or abandon their homes or habitual places of residence, particularly as a result of armed conflict, situations of generalized violence, or violation of human rights' (6). This event fractures the dimensions of material well-being and fundamental rights. This factor is associated with an increased stress and risk of cardiovascular disease (7) due to cultural change, even having a greater effect than adjustments in dietary patterns or physical activity (8). One of the key elements to achieve disease control refers to the recognition of therapeutic itineraries (TIs), trajectories that people build in search of their health, going beyond the doctor-patient relationship, linking intersubjective aspects and interactions between the subjects, the community, and the health system (9). TIs are individual care practices with sociocultural content that include the choice of practices based on different conceptions of the disease according to the social context, circumstances, available resources, experiences, interests, and conflicts (10). These TIs are little recognized and assumed in health systems at present.

In TIs, most people resort to different strategies to recover their health. Addressing the sociocultural contexts where these strategies are mobilized allows us to analyze the dynamics of the different actors involved in the health/illness/care process and the relationships between them. This process corresponds to a universal one that operates in all the social groups that make up society, where illness and disease are part of the social and cultural action (11), involving aspects of the political and economic order that explain the way in which care practices, behavior, and life habits are related. Thus, disease is defined by beliefs and values about health care and is circumscribed to cultural configurations where it is reproduced (12).

The objective of the study was to understand how migrant women with arterial hypertension configure their therapeutic itineraries in the search for health care within the health-illness-care process in Popayán, Colombia.

MATERIALS AND METHOD

The research adopted a qualitative design with a grounded theory (GT) approach, allowing for the identification of relationships between various categories that emerged from the participants' narratives. This method enables the interpretation of complex phenomena in the field of health, analyzing socially constructed experiences such as disease, access to and utilization of services, and therapeutic adherence (13). GT systematically collects data and continuously searches for relationships between them, adopting a historical hermeneutic approach that seeks to interpret and understand people's motivations through their daily actions. This approach facilitates the analysis of socio-historical facts to comprehend reality.

GT is based on symbolic interactionism, wherein people assume behaviors based on the meanings derived from their daily experiences (14), The researcher endeavors to define these meanings within the ways people relate to their context, approaching what individuals perceive as social reality. In this research, the GT process was pursued until the identification of relationships between emerging categories, without postulating a theory (15).

The research was conducted between October 2021 and June 2022 in Popayán, Colombia. Sixteen semi-structured interviews and two focus groups were conducted: one for data generation and the other for validation of the findings. A purposive theoretical sampling was carried out to collect empirical data, which were then analyzed and categorized by selecting internal migrant women from municipalities of the Department of Cauca with a diagnosis of AH. Interviews continued until reaching theoretical saturation and abstraction of emerging categories (15). The inclusion criteria were as follows: being an internal migrant woman due to forced displacement, being of legal age, having been diagnosed with AH, and having resided in Popayán for more than one year. The exclusion criteria were not suffering from cognitive or mental illnesses. All study participants were required to sign an informed consent form, wherein the purpose of the study and their rights in the research were explained verbally and in writing in detail. The custody and confidentiality of the information were in accordance with the Declaration of Helsinki (16). The study received approval from the Ethics Committee of the University of Cauca, as recorded in act No. 6.1-1.25/77 of June 2021. Both interviews and focus groups were recorded, transcribed in Microsoft Word®, copied to Microsoft Excel®, and analyzed using Atlas Ti ® version 8.1, while always preserving anonymity.

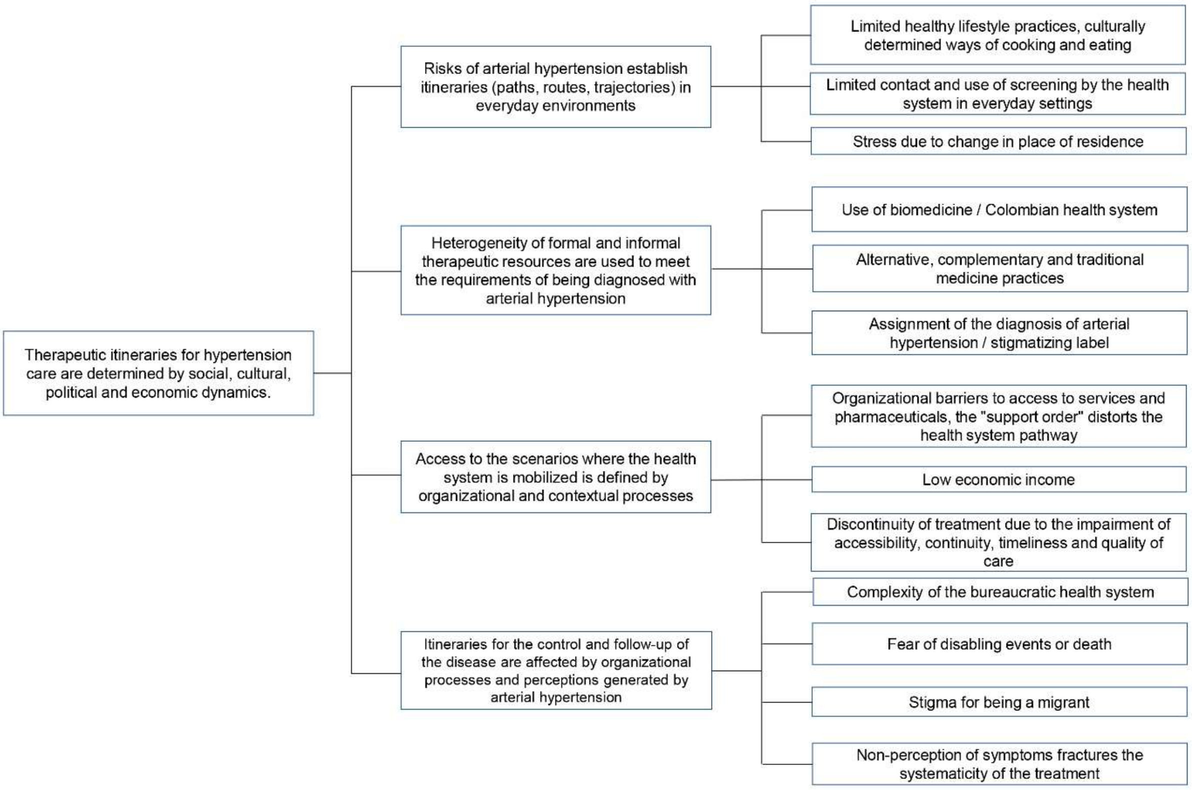
The analysis involved a process of coding and categorization carried out through three iterative moments: open coding, axial coding, and selective coding (15, 17). As the information was collected, microanalysis was conducted, involving a line-by-line examination of what was expressed by the participants in each interview. Open coding was utilized to capture as much data as possible. The researchers independently applied the open coding system to the women's narratives and then reconciled the emerging categories. This exercise resulted in 1,135 codes, which were organized in an Excel ® matrix and classified by themes. In this stage, theoretical questions were formulated to select concepts and explore their relationships. The data were carefully examined and compared to identify related categories and subcategories, thereby linking coincident data.

According to the grouping of the codes, categories were constructed to indicate a series of practices, events, and situations that were similar and directly related by their meaning (15). From this input, we proceeded to categorization, which consisted of grouping the codes to establish more complex units and relate them to the data. In this way, categories emerged that made it possible to explain the practices and relationships that women had in their daily lives to meet their health needs. This coding, called axial, related categories and subcategories to achieve precise explanations of the phenomenon, which occurred around the axis of the categories, linking them according to their dimensions and properties. Next, a paradigmatic matrix was made containing emerging elements that supported the understanding of the phenomenon. The paradigmatic matrix was then refined by carrying out the process of analytical reading and re-reading of data and constant comparison that led to the realization of selective coding, a process that integrated and refined the categories according to theory and reality. From this exercise, the main category and related subcategories were obtained.

RESULTS

The process of analyzing the information to understand the therapeutic itineraries of migrant women with AH allowed us to interpret that these trajectories, routes or paths, are determined by the logic of the health system and the categorical influence of social, cultural, political and economic dynamics, defined by the context in which they live. This main category is supported by four interrelated subcategories: risks of becoming ill from AH in everyday environments; heterogeneity of formal and informal therapeutic resources to treat the disease; processes of access to health system scenarios; and practices for follow-up and control (Figure 1).

Figure 1. Selective coding: main category and interrelated subcategories



Source: authors' elaboration

Risks of getting sick in everyday environments

The women interviewed described practices to limit conditions caused by AH in their sociocultural context. These practices include adopting a diet generous in fruits and vegetables while limiting fats, sugars, and salt. They also restrict alcohol and tobacco consumption and engage in physical activity. However, despite recognizing the importance of these aspects, their implementation is limited due to several factors that act as constraints. For instance, the influence of culture in the ways of cooking and eating poses challenges to adopting new dietary habits. Additionally, the type of food they can access is determined by cost and availability, which may limit their ability to consistently maintain a healthy diet. Physical activity, though acknowledged as beneficial, is not a daily practice for many women due to a lack of time, few sports venues, and the high cost of gyms.

> *"[...] in my house, we know what is good to eat, but sometimes we do not have the money to buy fish, chicken ... so we have to buy what is available in the store. Fruits and vegetables are the best, but they are also very expensive, and sometimes they stay there because the children and my husband do not like them. You can see what a struggle it is to get them to eat a plate of salad ..." (ITMM -0107).*

The women describe that the health system is not designed to have continuous contact with people in the neighborhoods, so blood pressure measurements are not taken in these settings. They report that their diagnosis process began when they started to perceive symptoms; they took their blood pressure at health days or consulted the hospital for other reasons.

> *“[…] nooo, no, no, no! They never come to take your blood pressure at home. Of course, if you don't go to the hospital, you don't even know what is happening to you... What they should do is have doctors come to your home to find out who is sick..." (ITMM -0102).*

One aspect that shapes the itineraries according to the participants refers to the change of residence due to the migratory process that requires leaving family, work, friends and home, generating situations of sadness, anxiety and stress when arriving in an unknown and perceived as aggressive territory, where there is a continuous struggle for survival.

Access to health system scenarios

The contact of the participants with the health system in low complexity determines the beginning of the therapeutic process. The designation as sick (patient) establishes trajectories to keep the disease under control. It is noteworthy that the assignment of the diagnosis to the woman operates as a stigmatizing label, who in addition to dealing with her daily life to provide for her family, must invest time and resources to maintain her health.

> *"[...] when the doctor told me that I was sick with blood pressure, uishhh God... I felt very bad... I thought that something serious could happen to me... arriving home and coming home with an illness is very hard, so you have to be more careful..." (ITMM -0115).*

In the TIs of the health system, women describe different barriers to access to medical consultation services, as well as to the delivery of pharmaceuticals, laboratory tests and diagnostic aids. These restrictions are determined by being migrants, limited hospital infrastructure, limited presence of health teams in the territories, long waiting times and administrative processes imposed by the actors of the system. The request for "support orders", a document required for the care and delivery of medicines that can affect access and restrict the continuity of treatment, is particularly noteworthy. The low economic capacity of women limits their access to the health system by having to pay for transportation to geographically dispersed hospitals and going to and from institutions due to administrative processes required by the system.

Heterogeneity of formal and informal therapeutic resources

Once the woman has been diagnosed, an itinerary refers to the use of low complexity hospitals where she is provided with monthly medications, paraclinical exams and health information. However, depending on the degree of affectation, the itineraries are directed to medium or high complexity hospitals, where different administrative processes must be processed for specialized care.

Not all women with AH use the official health system. Some resort to the use and consumption of medicinal plants from local herbal medicine, assessment by traditional health agents and divine intersection according to their religion. According to the symbolic efficacy that women assign to the different therapeutic practices and resources, whether from official or traditional medicine, they are recommended to other women.

> *“[…] one decides whether or not to go to the doctor, today it is much more difficult than before, you have to go a lot to get appointments, pills, and consultations with specialists, so what you do is to treat yourself with what you have, with what you can afford, for that there are several people who help you..." (ITMM -0119).*

Practices for control and follow-up

In the process of control and follow-up of AH, women describe that the continuity of treatment is affected by limited access to hospitals, discontinuity in the supply of medicines, low supply of services in the neighborhoods, limited opportunity and low quality of care, as well as complexity of the bureaucratic apparatus that requires administrative documents, validation of affiliation, payment of moderator fees, long lines; and use of information technologies (social networks, use of smartphones, internet and management of office automation systems).

> *“[…] You don't know how much you have to do to get the doctors to see you... You have to take some papers and take them to the health promotion company, then to the hospital. They must have signatures, and if they don't have them, they give them back to you, and you have to get them authorized... That is not easy, and you spend more time and money... You say, 'I'd better stay like this...” (ITMM -0105).*

The itineraries are also defined by the need to avoid disability or death, mobilized by the fear and apprehension generated by the warnings given by health professionals and technicians. The participants affirmed that because of their migratory status they are stigmatized in health care practices. On the other hand, the limited perception of symptoms can fracture the systematicity of treatment, leading to low therapeutic adherence. Likewise, in some cases, the women's leadership of the household has led them to abandon treatment, as they need to focus on obtaining resources to provide for their families.

DISCUSSION

Once AH is communicated as a disease to women, it is linked to the dynamics for the care of health and life, going beyond the actions of the biomedical scenario. The TI to achieve the control of AH allude to different processes circumscribed in the formal and traditional health system, integrating different curative resources available in the sociocultural fields where women live, as described by Lima et al. (18) from the logic of the health-disease-care process (12), in order to understand the trajectories assumed in the search for care to solve health needs.

The construction of trajectories, paths, routes, or itineraries links aspects related to culture, such as the adoption of healthy lifestyles that have shown a decrease in the risk of AH. However, their continuous and systematic adoption represents great challenges, as they go beyond personal decisions and depend on sociocultural, economic, and family dimensions. These findings are consistent with those described by Ferrer et al. (19) in studies on lifestyle dynamics. On the other hand, women perform therapeutic practices complementary to those offered in the state health model or in concomitance with it, including traditional, complementary, and alternative medicine. The use of these cultural practices has been associated with dissatisfaction with the conventional health system (20), beliefs about the effectiveness of treatment, accessibility to therapeutics, and the accentuated use in populations living in contexts of poverty and in rural areas (21).

Aspects from the political point of view configure itineraries. The operation of the system from a hospitalocentric approach, characterized by restrictions in community action, limits women's care. These findings are consistent with those referenced by Mera et al. (22) in the study of Colombian health policy. The participants express limitations from what would be the primary health care approach and the existence of organizational barriers to care. Similar results are related by Galindo et al. (23) from administrative, financial, and geographical aspects, especially in populations living in contexts of vulnerability. These effects affect the therapeutic process to such an extent that women may give up treatment (24). The multiple bureaucratic requirements for women's care complicate access and affect the itinerary within the health system. On the other hand, the limited access to the required health inputs and services coincides with the findings of García (25) in the study of the conditions of health services in Colombia, where care is compromised by inadequate criteria of quality, timeliness, and accessibility.

The economic dynamics shape itineraries. Women's financial limitations do not allow them to meet all the therapeutic recommendations (4). The participants report having little money for transportation, payment of moderator fees, purchase of drugs and other out-of-pocket expenses, restrictions that end up disrupting care. These findings are consistent with those described by Bran et al. (24) in their study of barriers to access to the Colombian health system. The migratory process per se generates changes in the itineraries when encountering inequities in health care, as described by Machado (26), either due to lack of support in navigating the system, high cost of care, discrimination from health actors and women's expectations about the quality of treatment. Studies have also related the existence of less access to health care for the migrant population compared to the native population (27).

From the social perspective, different categories are incorporated into the trajectories of the care process, including stigmatization for being a migrant and fear of discrimination (28). On the other hand, fear of disability generates anxiety and joint symptoms of depression, anger, or hostility (29) that exacerbate the presentation of cardiovascular events. Living with AH alludes to remaining with a silent disease that generates consequences in the social context, which becomes indifferent to the treatment of the condition (30).

As strengths of the study, it is specified that the approach linked to the research refers to taking into account different categories that make it possible to deepen the analysis of the determinants that define the success or failure of AH treatment, incorporating elements between the daily dynamics and the management of health services.

Limitations of the study are related to the restriction to make statistical generalizations according to the findings presented or to make inferences in other populations; however, the categories described can contribute to the understanding of what happens in contexts with similar characteristics.

CONCLUSIONS

Migrant women with hypertension configure their therapeutic itineraries in the search for health care not only from the state health system, but also based on various social, cultural, political and economic elements. To this extent, AH goes beyond morbid nominations that are exclusive to biomedicine and the doctor-patient relationship, to focus on and transcend a condition that involves bureaucratic burdens, barriers to access, discontinuity in care, stigmas and limitations in obtaining adequate treatment.

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