

## Policy Brief

# Reasons of low rates of men seeking medical care for high blood pressure

### Background

Currently, in Kyrgyzstan there is a significant gender gap in premature mortality from cardiovascular diseases. **In the age group from 0 to 64 years, male mortality rates is by 2.5 folds exceeding the female mortality from cardio-vascular diseases, by 3 folds from ischemic heart disease, and by 1.9 folds from cerebrovascular diseases.** The high mortality rate in males is determined by a number of factors, including high prevalence of smoking, poor awareness of health conditions such as high blood pressure.

In recent years, health research has consistently demonstrating men poorly utilizing primary healthcare services, which has resulted in late diagnostic and poor management of chronic conditions. According to the household survey in 2010, women sought primary healthcare services two times more than men over 18 y.o. The gap in service utilization between men and women aged from 19 to 39 y.o. could be explained by the fact that women in this age group increasingly seek services for reproductive health and pregnancy. However, in the age group of over 40 y.o., the over two-fold gap in health care utilization is persisting in favor of women. These significant gender gaps in healthcare utilization due to low uptake of PHC by men seems to explain the gaps observed in respect of mortality from cardiovascular diseases (CVDs) and essential hypertension. The premature mortality from cardiovascular diseases in males is higher than in females, although the prevalence of hypertension is higher in females than in males.

This study aims to identify reasons of low rates of seeking medical care in males with elevated blood pressure. Findings of the study should build grounds for developing a balanced approach that involves control of risk factors, community actions for health,

improving commitment of men to disease detection, and continuous disease control in healthcare organizations.

### Objective of the study

The study objective is to identify existing barriers for males with high blood pressure to seek primary healthcare services related to prevention and treatment of hypertension.

### Methodology

The study on causes of low rates of utilization of primary healthcare in males with elevated BP was performed during the action of 'Check your pressure', prior to the annual hypertension week, whereby village health committees (VHCs) across the country run BP measurements to maximum numbers of people.

All males who responded they previously had been aware of their high pressure were included in this study and asked questions using the developed tool.

The study also involved focus group discussions with males identified with high BP and with healthcare professionals working in FMCs / FGPs / FAPs.

### Key findings

Within the BP measurement campaign throughout the country held in 2015 in the regional centers, towns and villages, overall 480,289 people aged over 18 y.o. were examined, of whom 283,452 were females (59%) and 196,837 (40.9%) males.

As a result, 66,102 persons were identified with high BP (above 140/90 mmHg), which accounted for 13.6% of total examined.

16,776 persons first found they had high BP, which is 25.5% of total number of people with high BP identified during the screening. Of them, 74.6% of people knew they had high BP before the screening, out of them 68% had high BP and were receiving antihypertensive drugs.

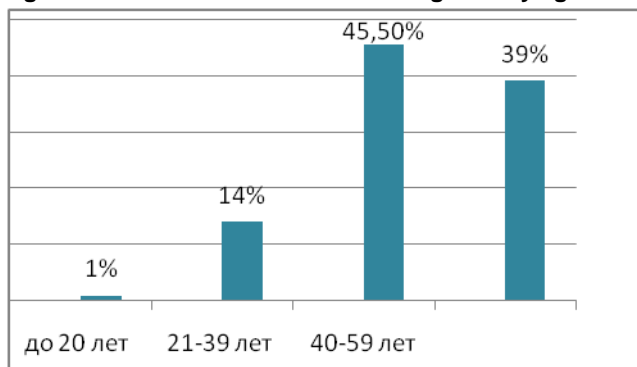
**Table 1. Results of activities to identify high BP in 2011-2015**

	2011	2012	2013	2014	2015
Number of examined persons	311342	403717	482273	577731	480289
Total identified with high BP	43024 (14%)	69539 (17%)	73843 (15%)	90131 (15%)	66102 (13,6%)
Number of persons first identified with high BP	13182	22077	21785	22265	16776 (25,5%)
Number of persons who were aware they had high BP among all identified with high BP	69,3%	68,2%	70,4%	75,2%	74,6%

Of all persons with BP (66,102) above 140/90 mm Hg, 68.7% were females and 31.5% were males.

Out of all males identified with high BP of all ages, 1% were young males aged under 20 y.o., 14% were males aged 21-39 y.o., 45.5% of males aged 40-59 y.o. and 39.2% of males aged over 60. The highest number of males identified with high BP was observed in the age groups of 40 - 59 and over 60.

**Figure 1. Distribution of males with high BP by age**



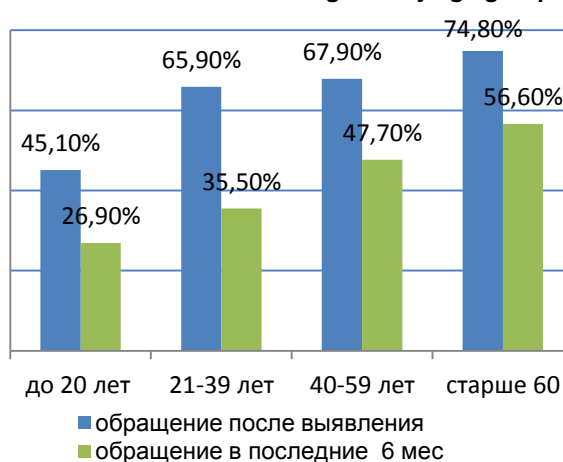
Of all males identified with high BP, 69% reported they had sought care in primary healthcare facilities after high BP was detected, with the remaining 31% never seeking care despite they had been previously aware of their high BP.

Of those males who visited the PHC after they were identified with high BP, 71.5% reported they had visited the PHC in the last 6 months.

Healthcare utilization in males due to high blood BP increased with age. The lowest rates of PHC service utilization was in males at working age of under 40 y.o. At this age, nearly half of males with high BP did not seek PHC service (Figure 2)

The number of males who sought healthcare in the last 6 months is even lower and was rising with age.

**Figure 2. Males seeking primary healthcare in the last 6 months after detection of high BP by age groups**



## Key conclusions

- There is lacking awareness of males about symptoms and consequences of elevated BP. Knowledge confined to headache. Males considered headache as main 'indicator' of hypertension and reported it as a reason to seek healthcare. Well-being, absence of headache and abnormalities in physical health status and ability to work represented the main reason for not seeking healthcare in males with elevated BP.
- Despite the fact that about 10% of males reported they did not go seek primary healthcare to control their condition due to lack of money, financial problems were not the most important reason of lower service utilization in males. Majority of males reported any visit to healthcare organization entails high expenditures and, therefore, they simply did not attend. This was primarily due to the quality of services for management of hypertension.
- Doctors were not committed to comply with clinical guidelines and protocols for hypertension and often prescribed inappropriate and expensive drugs that made patients, in particular males, to consider the

continuous BP control was associated with high expenditures for diagnosis and drugs.

- There are barriers to access healthcare services, in particular in rural area. In most cases, they are related to long hours waiting to receive consultation and regular follow-up examinations. Male residents of rural area have to attend the district or oblast level facilities to take examination, tests, consultations with specialists, etc.
- Most males do seek for healthcare and understand the regular follow-up examinations and control of treatment by healthcare professionals is needed only in critical situations, such as severe headaches or complications (heart attack, stroke).
- There is a common practice, particularly in rayon centers and rural area, of 'informal' follow-up of males with high BP, whereby males do not register and do not attend health care organizations and, at the same time, believe that doctors follow their conditions. Males and their families receive advice from friends practicing medicine through various channels (telephone, through family members, when they met by chance, and others.).
- Discussion of why are healthcare workers not registering patients with hypertension identified two main reasons: i) because of poor access males with hypertension did not take all required diagnostic tests, which represent precondition for doctors to register the patient with hypertension; ii) high number of registered patients with hypertension results in persisting checks of documents by MHIF, as hypertension is a monitored disease within the contractual relations of healthcare organizations and MHIF; when checks of outpatient cards of patients with hypertension detect violations, the MHIF imposes penalties on physicians. Therefore, to avoid responsibility, doctors tend to have as little as possible the number of registered patients.
- Lack of doctors' commitment to apply the approved clinical protocols for hypertension suggests the protocols were not put into practice on the ground, doctors were not trained on use of these recommendations. Drafting the recommendations for clinical laboratory diagnostics did not account for local conditions and laboratory test capacities in

healthcare organizations, which was one of barriers for adherence to approved guidelines and protocols on treatment and registration of patients with hypertension.

## Recommendations

- There is a need to develop specific information materials for males focused on risks and symptoms of elevated BP, with dissemination and communication through VHCs and primary healthcare workers.
- It is necessary to develop rigorous mechanisms to establish communications between VHCs and healthcare organizations, so that data on persons with elevated BP, in particular males, transferred from VHCs to FMC/FGP were recorded, monitored and registered, if necessary (register patients as hypertension case subject to follow up).
- Address the issue of motivation of PHC workers incase detection and registration of patients with hypertension. In this regard, consider provisions in clinical guidelines and protocols in terms of registration of patients and develop simple criteria based diagnostic methods available at all levels, which represent a pre-requisite for registration of patients with elevated BP. At the same time, consider the appropriateness of introducing a temporary moratorium on sanctions of the MHIF and other agencies related to monitoring of cases with hypertension.
- Expand powers and functions of nurses in management of hypertension in the framework of existing public awareness building and public education programs, in particular those focused on males. Transform the functions of detection of hypertension cases, registration of risk factors to be nurse functions.
- Update the approved clinical guideline and protocols for hypertension for primary healthcare and revise recommendations on laboratory and instrumental diagnostics guided by available equipment and local conditions. Implement the developed clinical guidelines and protocols, specifically through training of specialists in the field.