

SOCIAL INEQUALITIES AND HYPERTENSION CONTROL IN PRIMARY HEALTH CARE: AN INTEGRATIVE REVIEW

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Abstract

Hypertension remains a major public health problem, and its control is influenced by both living conditions and the organization of health services. Objective: to analyze social inequalities related to the diagnosis, follow-up, and control of hypertension in the context of Primary Health Care. Method: an

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integrative literature review guided by the stages of question formulation, searching, selection, extraction, critical appraisal, and synthesis. The guiding question was: how do social determinants influence hypertension control among adults followed or reached by Primary Health Care? A preliminary search was conducted in PubMed/MEDLINE, covering publications from January 2020 to September 2026 in Portuguese, English, or Spanish. Original studies involving adults were considered if they analyzed blood pressure control or stages of the care continuum and at least one social, economic, racial or ethnic, territorial, or health care access marker. Eighteen studies were included in the preliminary synthesis. Results: lower income, unstable health care coverage, geographic barriers, residence in disadvantaged areas, racial and ethnic inequalities, low health literacy, and weak continuity of care were associated with poorer trajectories of diagnosis, adherence, and control. Treatment availability alone did not eliminate differences between social groups. Longitudinal relationships, regular access, person-centered organization, and place-based strategies showed potential to reduce these gaps. Conclusion: hypertension control does not depend solely on individual decisions or medication prescribing. It results from the interaction between living conditions and the ability of Primary Health Care to provide access, continuity, and care that is responsive to inequalities. Independent double-checking of study selection and data extraction must be completed before manuscript submission.

Keywords: Blood Pressure Control, Health Inequities, Hypertension, Primary Health Care, Social Determinants of Health.

INTRODUCTION

Hypertension is a chronic condition of major public health importance because of its prevalence, frequently silent course, and association with cardiovascular, cerebrovascular, and renal events (World Health Organization, 2023; Barroso et al., 2021). The problem, however, extends beyond identifying elevated blood pressure values. Between recognizing the condition, initiating treatment, maintaining follow-up, and achieving sustained control lies a sequence of stages at which patients may be lost. These

losses constitute a care continuum marked by late diagnosis, treatment interruptions, irregular access to services, and difficulty integrating self-care measures into daily life.

The World Health Organization identifies hypertension as one of the leading preventable causes of illness and premature death and notes that a large proportion of affected individuals do not achieve adequate control (World Health Organization, 2023). The challenge is particularly pronounced in low- and middle-income countries, but it is not limited to them. Even in systems where medications and services are widely available, differences persist according to income, educational attainment, race or ethnicity, place of residence, health care coverage, and working conditions. Population-level control averages may therefore conceal groups that remain systematically excluded from the benefits achieved by other segments of the population.

The social determinants of health framework helps explain why individuals with the same diagnosis do not have the same opportunities for care. Limited income may have to compete with expenditures on food, transportation, and housing; lower educational attainment does not automatically mean limited knowledge, but it may coincide with inaccessible materials and inadequate communication by health professionals; living far from a health facility or in an unsafe area may hinder regular attendance at appointments; and employment instability may prevent individuals from attending services during operating hours. Thus, behaviors frequently treated as individual choices are conditioned by concrete opportunities and socially distributed constraints.

This discussion is particularly relevant to Primary Health Care (PHC). As the preferred point of entry into the health system and the setting for longitudinal follow-up, PHC is well positioned to screen for, diagnose, treat, and monitor hypertension. It can also integrate health education, pharmaceutical care, dietary counseling, physical activity, psychosocial support, home visits, and coordination with other levels of care. However, the mere presence of a health facility does not guarantee timely access, an ongoing therapeutic relationship, or continuity of care. The ability to reduce inequalities depends on how

services organize appointment schedules, teams, active outreach, communication, medication availability, and responses to the characteristics of the local area (World Health Organization, 2025).

Blood pressure control is often presented as an individual clinical outcome, but it also serves as an indicator of health system quality and equity. When certain groups are less likely to meet blood pressure targets even after entering treatment, it is necessary to examine not only adherence and lifestyle but also the appropriateness of the care received. Recent studies have investigated differences associated with income, migrant background, health care coverage, race, rurality, and spatial accessibility, but their findings are dispersed across countries and methodological designs (Metlock et al., 2024).

Given this dispersion, the present review focuses on social inequalities and how they affect the different stages of the care continuum. The aim is not to produce an undifferentiated list of risk factors, but to understand which social conditions and service characteristics increase or reduce the likelihood of control among population groups.

This synthesis may support the work of different professional groups. Physicians, nurses, and pharmacists participate directly in diagnosis, treatment adjustment, and follow-up; dietitians and Physical Education professionals contribute to nonpharmacological components of care; physiotherapists support functional capacity and the management of associated conditions; and psychologists and social workers help address distress, access barriers, and vulnerabilities. The relevance of a multiprofessional approach, however, does not mean diluting responsibilities. It means recognizing that sustained control requires clinical, educational, organizational, and intersectoral action.

Against this background, this study aimed to analyze social inequalities related to the diagnosis, follow-up, and control of hypertension within Primary Health Care. It sought to identify the determinants most frequently examined, the mechanisms suggested by the studies, and the implications for equity-oriented care.

METHOD

STUDY DESIGN AND RESEARCH QUESTION

This is an integrative literature review. This method makes it possible to bring together studies with different designs to develop a comprehensive understanding of clinical and organizational problems, provided that the research question, selection criteria, and synthesis method are transparently reported. The stages considered were problem identification, literature searching, study appraisal, data analysis, and presentation of the synthesis (Whittemore; Knafl, 2005; Mendes; Silveira; Galvão, 2008).

The question was structured using the PICO strategy: population (P), adults with hypertension; phenomenon of interest (I), inequalities and social determinants related to diagnosis, treatment, or control; and context (Co), Primary Health Care and community-based services performing equivalent functions. The guiding question was: how do social determinants influence hypertension control among adults followed or reached by Primary Health Care?

SEARCH STRATEGY

The preliminary search was conducted in PubMed/MEDLINE on September 8, 2026. Controlled vocabulary and free-text terms related to hypertension, blood pressure control, social determinants, and Primary Health Care were combined. In summary, the following strategy was used: (Hypertension OR hypertens*) AND (uncontrolled OR blood pressure control OR controlled blood pressure) AND (Social Determinants of Health OR socioeconomic* OR income OR education OR race OR ethnicity OR insurance OR food insecurity) AND (Primary Health Care OR primary care), limited to the period from January 2020 to September 2026.

The strategy retrieved 226 identifiers. At the time of automated data collection, five records did not have a bibliographic structure equivalent to that of an indexed article, leaving 221 records available for preliminary screening. The selection reported in this manuscript resulted in 18 potentially eligible

studies. To ensure methodological integrity, the final numbers of exclusions at each stage and the supplementary search in LILACS/BVS, SciELO, and Scopus must be verified by two independent reviewers before submission. The flow reported here therefore describes the preliminary stage and should not be converted into a final PRISMA flow diagram without this verification (Page et al., 2021).

Official documents and review studies were also consulted to support the introduction and discussion, but these materials were not included in the sample of primary studies. This separation prevents evidence used for contextualization from being combined with the articles subjected to comparative data extraction.

ELIGIBILITY CRITERIA

Original studies published in Portuguese, English, or Spanish were included if they involved individuals aged 18 years or older; were conducted in PHC, community-based services, or population-based databases with an explicit assessment of the care continuum; and reported blood pressure control, diagnostic awareness, treatment, adherence, or continuity of care as an outcome. Studies were also required to analyze at least one social marker: income, educational attainment, occupation, race or ethnicity, migration, health care coverage, local conditions, rurality, economic vulnerability, geographic access, health literacy, or resource availability.

Protocols, editorials, reviews, exclusively hospital-based studies, research on secondary hypertension or gestational hypertension, studies that did not report hypertension outcomes separately, and articles focused solely on pharmacological or physiological efficacy were excluded. Interventions were considered only when they included an analysis of access, equity, or differences between social groups.

DATA EXTRACTION, APPRAISAL, AND SYNTHESIS

Preliminary data extraction covered authorship, year, country, study design, population, care setting, outcome definition, determinants analyzed, and main findings. The findings were grouped into four domains: socioeconomic position and financial protection; geographic area and access to PHC; race, ethnicity, and migration; and conditions that mediate care, such as health literacy, therapeutic relationships, and continuity. The heterogeneity of definitions and measures precluded an appropriate quantitative combination; therefore, a narrative synthesis was conducted.

The methodological appraisal considered alignment between the research question and study design, clarity in defining the population, blood pressure measurement, control of confounding, and consistency of the conclusions. Most observational studies can identify associations but not causality. A formal appraisal using Joanna Briggs Institute instruments must be conducted independently by two reviewers and appended to the submitted version. No artificial scores were assigned in this version because such a procedure would require a complete, paired review of the full texts.

ETHICAL CONSIDERATIONS

Because this review uses only published, document-based data, it does not involve participant recruitment or access to identifiable information and therefore does not require submission to the Brazilian Research Ethics Committee/National Research Ethics Commission system (Sistema CEP/Conep). Nevertheless, the responsibilities of proper citation, fidelity to the findings, disclosure of author contributions, and transparency regarding the limitations of the search remain applicable.

RESULTS

CHARACTERISTICS OF THE STUDIES

The preliminary synthesis included 18 studies published between 2020 and 2026. The set comprised studies from the United States, Colombia, Mexico, Sweden, the United Kingdom, India, South Africa, Malaysia, the Philippines, China, Haiti, and Bangladesh. Eight studies were conducted entirely in the United States, reflecting the greater availability of electronic databases recording race, insurance, and health center characteristics. The remaining studies broadened the analysis to universal health systems, middle-income countries, and contexts of urban poverty, rurality, or humanitarian crisis.

Cross-sectional studies, community surveys, and analyses of health care records predominated. Retrospective cohorts, a population-based cohort with follow-up, a mixed-methods study, and a qualitative investigation were also identified. Sample sizes ranged from slightly more than two hundred participants to hundreds of thousands of records. This breadth strengthens contextual diversity but makes direct comparisons difficult because the studies used different thresholds to define control, and not all distinguished patients receiving treatment from those who had not yet been diagnosed.

Table 1 presents the characteristics of the studies. The results were not interpreted as though all studies carried equal weight. Large databases provide precision and subgroup analyses but may lack information on everyday experiences and barriers. Qualitative and mixed-methods studies help explain mechanisms, although they do not estimate the magnitude of associations.

Table 1

Characteristics of the Studies Included in the Preliminary Synthesis

Study	Setting/design	Social dimension	Summary of findings
Kressin et al., 2020	United States; retrospective cohort; 43,785 patients	Insurance instability and race/ethnicity	Stable coverage was associated with better control; uninsured Black individuals had the least favorable outcomes.
McDoom et al., 2020	United States; cross-sectional; 5,970 patients	Income and neighborhood environment	After adjustment, neighborhood characteristics were no longer associated with blood pressure control, indicating that contextual findings were not uniform.
Londoño Agudelo et al., 2021	Colombia; cross-sectional; 1,873 adults	Low income, education, and gaps in care	Underdiagnosis, nonadherence, and uncontrolled hypertension persisted; insufficient follow-up and nonpharmacological counseling exacerbated losses along the care continuum.
Gallardo-Rincón et al., 2021	Mexico; retrospective; 743,000 screenings	Education, geographic area, and access	Only a small proportion were linked to a health facility after screening; rural or urban setting, access, and educational attainment influenced their trajectories.
Mourtzinis et al., 2021	Sweden; retrospective cohort; 48,254 patients	Income and country of birth	Lower income and birth outside Sweden were associated with a lower likelihood of achieving the target; educational attainment showed no association.
Luo et al., 2022	United States; COMPASS cohort; 5,096 adults	Spatial accessibility	Greater spatial availability of PHC was associated with higher levels of diagnostic awareness and control.
Eastwood et al., 2023	United Kingdom; retrospective cohort; 782,000 patients	Ethnicity and treatment continuity	Control was lower among people of African/Caribbean origin; the difference narrowed after accounting for persistence and adherence.
Singh et al., 2023	India; cross-sectional; 8,850 adults in a slum/resettlement area	Urban poverty and continuity	A high proportion remained undiagnosed, and control was low; smoking was associated with lower adherence.
Makukule et al., 2023	South Africa; cross-sectional; 400 patients	Socioeconomic deprivation and behaviors	Uncontrolled hypertension was associated with adherence, salt consumption, alcohol, tobacco, inactivity, and greater treatment complexity.
Alosi; Curtis, 2024	United States; analysis of community health centers	Race/ethnicity and service organization	Black patients had lower control rates; centers with a person-centered care model achieved better outcomes.
Adediran et al., 2024	United States; cross-sectional; 24,915 patients	Race/ethnicity and coverage	Uncontrolled hypertension was more likely in some racial groups and among individuals without regular coverage.
Kishore et al., 2024	United States; ecological; 1,205 centers	Clinical need, race/ethnicity, and funding	Greater need arising from uncontrolled hypertension was not consistently translated into greater federal funding per patient.
Palafox et al., 2025	Malaysia/Philippines; cross-sectional; 1,191 low-income adults	Income, geographic area, and care pathways	Care pathways differed between countries and between urban and rural areas, requiring context-specific responses.

Study	Setting/design	Social dimension	Summary of findings
Yin et al., 2025	Rural China; mixed methods; 7,488 adults and 82 interviews	Rurality, resources, and beliefs	Low perceived need, fear of treatment, limited diagnostic capacity, and irregular follow-up explained gaps in care.
Metz et al., 2025	Haiti; cohort; 3,005 adults	Extreme poverty and civil unrest	Free care and follow-up improved diagnosis, treatment, and control, although younger adults continued to have poorer control.
Yepez et al., 2025	United States; cross-sectional; 218 participants, most of whom were Hispanic	Regular access to PHC	Having a usual PHC professional was independently associated with better blood pressure control.
Kramer et al., 2026	United States; qualitative; 54 interviewees across 14 clinics	Resources, health literacy, rurality, and mental health	Health literacy, available resources, person-centered care, and psychological distress affected management.
Monower et al., 2026	Bangladesh; national surveys; 27,427 adults	Income, education, sex, and geographic area	Control improved over time, but inequality favoring the wealthiest groups increased.

Source: Prepared by the authors based on the included studies (2026).

SOCIOECONOMIC POSITION AND FINANCIAL PROTECTION

Income emerged as a recurring marker, but its effect varied according to the health system. In Sweden, even in a context of universal coverage, individuals in the lowest income stratum were slightly less likely to achieve the blood pressure target. In Bangladesh, control improved between the two surveys analyzed, but the concentration of better outcomes among the wealthiest groups increased (Mourtzinis et al., 2021; Monower et al., 2026). These findings indicate that an overall expansion of care may coexist with a relative widening of inequalities when socially advantaged groups benefit more rapidly.

Financial protection exerted a direct influence in the United States. Insurance instability was associated with a higher frequency of uncontrolled blood pressure, with the least favorable situation observed among Black individuals who remained continuously uninsured. In another study, the lack of regular insurance or reliance on out-of-pocket payment was associated with uncontrolled hypertension. Public funding, in turn, was not distributed in a consistently proportional manner relative to the clinical needs of community health centers (Kressin et al., 2020; Adediran et al., 2024; Kishore et al., 2024). It is therefore not enough to increase total resources; they must be allocated according to disease burden, social complexity, and local capacity to respond.

In studies of low-income communities in Colombia, India, Malaysia, and the Philippines, economic vulnerability was accompanied by discontinuous care trajectories. Entry into treatment did not guarantee follow-up, adherence, or adequate counseling (Londoño Agudelo et al., 2021; Singh et al., 2023; Palafox et al., 2025). Indirect costs, travel time, informal employment, and previous experiences with services may explain some of these losses, although not all studies measured each mechanism separately. It is methodologically inappropriate to attribute a single effect to income: income operates through food, transportation, housing, opportunities for rest, the purchase of medications during shortages, and the availability of time for care.

GEOGRAPHIC AREA, RURALITY, AND ACCESS TO PRIMARY HEALTH CARE

The studies showed that access encompasses more than physical distance. In Chicago, greater spatial accessibility to PHC services was associated with higher levels of hypertension awareness and control. Among predominantly Hispanic participants, having a usual primary care professional reduced the prevalence of uncontrolled blood pressure even after adjustment for demographic characteristics and coverage (Luo et al., 2022; Yepez et al., 2025). These results reinforce the importance of a regular point of care that can monitor outcomes, renew prescriptions, and recognize failures before they become prolonged interruptions.

In Mexico, a digital screening strategy reached a large number of individuals who had no previous access to care, but only a small proportion were effectively linked to the corresponding health center. This finding exposes the difference between detecting risk and ensuring care. Screening programs that accumulate screening results without referral, follow-up, and monitoring mechanisms may increase the number of recorded diagnoses without producing sustained clinical control (Gallardo-Rincón et al., 2021).

In China, rurality was associated with diagnostic limitations, a smaller health workforce, and inconsistent follow-up. However, rural areas should not automatically be regarded as synonymous with

failure. Their effects depend on transportation, the geographic reach of health teams, medication stocks, trust in professionals, and community engagement. In Malaysia and the Philippines, care pathways differed between urban and rural areas, demonstrating that the same strategy may produce different effects depending on local organization (Yin et al., 2025; Palafox et al., 2025).

Haiti provided a relevant counterpoint: even amid extreme poverty and civil instability, free access to regular follow-up improved diagnosis, treatment, and control over two years (Metz et al., 2025). This result does not negate the influence of the crisis, but it demonstrates that adverse social conditions do not render care ineffective. Accessible and sustained services can reduce substantial losses, provided that they maintain longitudinal relationships and operational capacity.

RACIAL AND ETHNIC INEQUALITIES, MIGRATION, AND BELONGING

Racial and ethnic inequalities were most extensively documented in the United States and the United Kingdom. In US community health centers, Black patients had lower blood pressure control rates than White and Hispanic patients. In large primary care databases, Black and Native Hawaiian or Pacific Islander patients were also more likely to have uncontrolled blood pressure (Alosi; Curtis, 2024; Adediran et al., 2024). These results should not be interpreted as indicating biological differences inherent to these groups. Race and ethnicity serve as markers of social experiences, discrimination, economic inequality, access, environmental exposure, and differences in the quality of care.

In the United Kingdom, individuals of African or Afro-Caribbean origin had lower control rates after treatment initiation. The difference was attenuated when the models accounted for medication persistence and adherence, suggesting that the key issue was not limited to the initial prescription (Eastwood et al., 2023). Subsequent continuity, the appropriateness of follow-up, and the conditions needed to maintain treatment explained part of the inequality. This finding shifts the focus from presumed individual resistance to the trajectory produced through the relationship between patients and the health system.

Country of birth was also associated with achieving blood pressure targets in Sweden. Individuals born outside the country were less likely to achieve control than those born in Sweden (Mourtzinis et al., 2021). Language barriers, familiarity with the system, recognition of previous prescriptions, and migration experiences may contribute to this process, although these factors should not be presumed without measurement. The practical implication is that services should provide accessible communication and culturally responsive care without stereotyping patients.

HEALTH LITERACY, THERAPEUTIC RELATIONSHIPS, ADHERENCE, AND LIVING CONDITIONS

Health literacy emerged as a cross-cutting mechanism. In interviews conducted in services with differing levels of performance, professionals and patients highlighted difficulties in understanding the condition, assessing risks, and incorporating recommendations into daily routines. Low health literacy does not correspond solely to formal educational attainment. It also reflects the clarity of institutional communication, the complexity of treatment regimens, and the ability of services to adapt information to patient needs (Kramer et al., 2026).

Adherence was an important mediator, but it was not sufficient to explain all differences. In South Africa, high salt intake, alcohol and tobacco use, lower physical activity, poor adherence, and a larger number of medications were associated with uncontrolled hypertension. In India, tobacco use was associated with lower adherence (Makukule et al., 2023; Singh et al., 2023). These behaviors have an individual dimension, but they are also influenced by food availability, working conditions, the neighborhood environment, psychological distress, and social support.

Mental health emerged in the qualitative analysis as a factor capable of affecting management. Anxiety may intensify symptoms and the perception of risk, whereas depression may reduce motivation and the ability to maintain routines. This finding supports a comprehensive approach in PHC without

turning every difficulty with adherence into a psychiatric diagnosis. Listening, assessing distress, and coordinating psychosocial support may be necessary when cardiovascular care encounters persistent emotional barriers.

Taken together, the studies suggest that therapeutic relationships and continuity constitute points of convergence. Access to an isolated appointment, receipt of a prescription, or participation in screening is not equivalent to having longitudinal care. Control improves when scheduled follow-up, opportunities for treatment adjustment, a designated professional or care team, and understandable communication are available.

DISCUSSION

BLOOD PRESSURE CONTROL AS A SOCIAL AND HEALTH CARE OUTCOME

The synthesis shows that hypertension control is produced at the intersection of living conditions and service functioning. An interpretation centered solely on individual adherence is insufficient because it overlooks who can reach the health facility, understand the guidance provided, obtain medication, return for assessment, and reorganize their routine. When these conditions are unequally distributed, control also tends to be unequal.

The results are consistent with contemporary approaches to the social determinants of health, according to which education, economic stability, access to care, the local environment, and the social context shape prevention and management (Metlock et al., 2024). However, the review also found nonuniform results. In the Baltimore study, neighborhood characteristics were no longer associated with hypertension control after adjustment. In Sweden, educational attainment was not associated with the outcome, whereas income and country of birth remained relevant (Mcdoom et al., 2020; Mourtzinis et al., 2021). These divergences are important: social determinants do not operate as universal markers independently of context. Their effects depend on social protection policies, health system design, and correlations among variables.

This heterogeneity reinforces the need to avoid simplistic generalizations. Lower income may have different consequences in systems that provide free medications and in insurance-based settings. Similarly, rural residence may mean isolation from health care in one area and a strong presence of community health workers in another. Equity requires identifying the specific mechanism of disadvantage rather than merely classifying patients as vulnerable.

IMPLICATIONS FOR PRIMARY HEALTH CARE

PHC occupies a strategic position because it follows most people with hypertension and can intervene before complications develop. To perform this role, it must organize a pathway that extends beyond episodic consultations. Screening must be linked to diagnostic confirmation; diagnosis must generate a shared plan; prescriptions must be followed up; and uncontrolled blood pressure must trigger active outreach, treatment review, and investigation of barriers.

The findings support at least five areas of action. The first is to stratify not only cardiovascular risk but also the risk of loss to care, including frequent absences, transportation difficulties, unstable coverage, low income, language barriers, and psychological distress. The second is to make access more flexible through alternative hours, safe prescription renewal, home-based or remote follow-up when appropriate, and integration with community health workers. The third is to simplify treatment regimens and ensure a continuous medication supply. The fourth is to improve communication through plain language, confirmation of understanding, and accessible materials. The fifth is to monitor indicators by geographic area, race/color, sex, and socioeconomic status because overall averages may conceal systematically disadvantaged groups.

Multiprofessional practice should be organized around needs rather than around the accumulation of fragmented encounters. Nursing can coordinate monitoring and education; medicine contributes to clinical assessment and pharmacological adjustment; pharmacy supports medication reconciliation, safety,

and regimen simplification; nutrition assists with dietary choices compatible with patients' resources and culture; Physical Education and physiotherapy professionals can develop safe strategies to support movement and functional capacity; and psychology and social work help address distress and social barriers. The shared outcome should be continuity of the care plan, with contradictory recommendations avoided.

The study of community health centers indicated better outcomes where care was organized around the person (Alosi; Curtis, 2024). This approach does not mean mere courtesy. It involves understanding priorities, agreeing on achievable goals, adapting management, and maintaining shared responsibility for follow-up. Individuals should not be held solely responsible for a plan that is unfeasible given their income, employment, transportation, or family caregiving responsibilities.

EQUITY, MONITORING, AND PUBLIC POLICY

Reducing inequalities requires information capable of revealing their distribution. Record systems should make it possible to monitor coverage, diagnosis, treatment, and control according to relevant social characteristics while protecting confidentiality. When differences emerge, the indicator must guide resources, supervision, and care redesign. The analysis of US health center funding showed that greater clinical need was not always translated into greater funding per patient, revealing the limitations of models that allocate resources without adequately incorporating the burden of vulnerability (Kishore et al., 2024).

In Brazil, the Unified Health System (Sistema Único de Saúde, SUS) provides the normative foundation for universality and equity, and the Family Health Strategy (Estratégia Saúde da Família, ESF) has the territorial reach needed to address hypertension. Nevertheless, nominal coverage does not ensure continuity, team availability, or effective problem-solving capacity. Local planning must integrate patient registration, standardized blood pressure measurement, diagnostic confirmation, regular medication dispensing, follow-up, and community-based action. The Clinical Protocol and Therapeutic Guidelines

for Hypertension reinforce the need for adherence and follow-up, but their implementation depends on municipal capacity, continuing professional education, and monitoring (Brasil, 2026).

Intersectoral policies are also necessary. Adequate food, urban mobility, neighborhood safety, social protection, and working conditions influence the ability to follow recommendations. PHC cannot resolve structural inequalities on its own, but it can identify them, document their effects, coordinate responses, and prevent them from being converted into individual blame.

LIMITATIONS AND STRENGTHS OF THE REVIEW

This review has limitations that prevent its results from being interpreted as definitive estimates. The primary search was conducted in a single international database, and the screening process still requires independent double-checking. Studies published in Portuguese and Spanish may be underrepresented. The greater presence of US data broadens the discussion of race and insurance but limits direct transferability to universal health systems. In addition, different thresholds were used to define control, and some studies assessed the entire care continuum, whereas others included only individuals receiving treatment.

The predominance of cross-sectional designs precludes the establishment of temporality. An association between low income and uncontrolled hypertension, for example, does not by itself demonstrate a causal pathway. Self-reported measures of adherence, diet, and substance use are susceptible to bias. There was also heterogeneity in how race, ethnicity, migration, income, and geographic area were recorded, making a pooled statistical synthesis unfeasible.

A strength of this review is that it integrates quantitative, qualitative, and mixed-methods studies and simultaneously examines individual, territorial, and organizational factors. Its focus on inequalities avoids duplicating general reviews of adherence and highlights mechanisms that PHC can modify. For the final version, the search should be expanded to LILACS/BVS, SciELO, Scopus, or Web of Science, the

paired critical appraisal should be completed, and reasons for exclusion should be recorded in a PRISMA flow diagram.

CONCLUSION

The evidence reviewed indicates that social inequalities permeate every stage of hypertension care. Lower income, unstable coverage, geographic barriers, racial and ethnic inequalities, migration, low health literacy, and weak therapeutic relationships can reduce the likelihood of timely diagnosis, adherence, follow-up, and control. These factors do not operate in isolation, nor do they have the same effects across all systems.

Blood pressure control should therefore not be reduced to individual responsibility or the availability of a prescription. PHC must combine regular access, understandable communication, medication availability, monitoring, coordinated multiprofessional care, and responses adapted to local conditions. Universal strategies should be accompanied by an intensity proportionate to need so that improvements in average outcomes do not preserve or widen disparities between groups.

The methodological conclusion is also clear: the manuscript has a consistent theoretical foundation and preliminary synthesis, but it will be ready for submission only after the supplementary search, independent selection, complete verification of the studies, and disclosure of each author's contributions have been completed. This is not a bureaucratic requirement; it is what transforms a well-founded text into a reproducible scientific review.

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