DOI: 10.15253/2175-6783.2016000400019
www.revistarene.ufc.br

Original Article

Experiences of community health agents in the care of the elderly affected by chronic diseases

Vivências de agentes comunitários de saúde na atenção a idosos acometidos por doenças crônicas

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Objective: to understand which are the experiences of community health agents in the care of patients with chronic diseases. **Methods:** qualitative research carried out through the interview of 20 community health agents. Data were analyzed following the steps of content analysis. **Results:** the care for the elderly has limitations due to their low educational level, resistance to adhere to drug therapy and low frequency of visits to health facilities. Another reason is the aging process in itself that may compromise the ability of self-care and the development of daily activities. **Conclusion:** difficulties of community health agents were identified in the care of elderly people with chronic diseases due to low adherence to treatment and to the health service.
Descriptors: Aged; Chronic Disease; Community Health Workers; Nursing.

Objetivo: compreender como se dão as vivências de agentes comunitários de saúde na atenção a idosos acometidos por doenças crônicas. **Métodos:** pesquisa qualitativa, com 20 agentes comunitários de saúde entrevistados. Dados analisados seguindo os passos da análise de conteúdo. **Resultados:** a atenção aos idosos tem limitações em função da reduzida escolaridade destes, a resistência em aderir à terapia medicamentosa e a pouca frequência às unidades de saúde. Também, ao próprio processo de envelhecimento, que pode comprometer o cuidado de si e a realização de atividades diárias. **Conclusão:** identificaram-se dificuldades dos agentes comunitários de saúde na atenção a idosos com doenças crônicas, uma vez que há pouca adesão destes ao tratamento e ao serviço de saúde.
Descritores: Idoso; Doença Crônica; Agentes Comunitários de Saúde; Enfermagem.

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Received: Apr. 4th 2016; Accepted: Mayo 12nd 2016.

Introduction

Life expectancy and the elderly has gradually increased worldwide and this has been accompanied by demographic transition divided into three phases, which occurs in most countries: 1st phase: high rates of mortality and fertility; 2nd phase: decrease in mortality and population growth; and 3rd phase: decrease in fertility and population aging[1]. These steps are monitored and influenced by health care offered by services that increasingly direct their activities to community, family and individual characteristics aiming to favor the promotion, recovery and rehabilitation of health of people who experience illness in every stage of their life.

It is during old age that most people are affected by some morbidity, in particular by one or more non-transmissible chronic diseases, experienced by the elderly for long clinical periods, and that may lead to organic and psychic weakness. Moreover, older people have partial knowledge on chronic diseases[2]. Therefore, there is a need for the elderly to learn the factors that contribute to the development of these morbidities. In addition, health services should improve health education programs, focusing on older males with less education, with poor access to health care and family history of chronic diseases and who do not participate in group activities[2].

It is observed that elderly patients with chronic diseases tend to get worse and worse with the aging process, which explains the high prevalence of these diseases. From the point of view of the absence of diseases, the number of years lived free from morbidities is relatively low, since the prevalence of chronic diseases among the elderly is high. Among older women, estimates of expectancy of life with good health and without functional disability are almost five times higher than the expectancy of life free from chronic diseases[3].

Actions created by the Ministry of Health of Brazil regarding strategies for the care of individuals with chronic disease focus on the four groups of morbidities with largest worldwide impact, namely, those of the circulatory system, diabetes, cancer and respiratory diseases. These have four risk factors in common: smoking, excessive alcohol consumption, unhealthy diet and physical inactivity[4].

The actions planned for combating smoking and excessive alcohol consumption are intended to guide people about the risks arising from these practices and the benefits that come from their interruption, ways of dealing with the withdrawal syndrome, the psychological and physical addiction, as well as acute decompensation of chronic diseases[4]. Regarding nutrition and physical inactivity, the focus is given on the control and prevention of chronic diseases, recommending actions of exercise, which produce energy expenditure and reduce the risk of developing chronic conditions[4]. This is because when the individual puts himself as the protagonist of self-care, he contributes to human development, cultivating functional and structural plenitude[5].

The Ministry of Health of Brazil created the Ordinance nº 648/GM of March 28, 2006, which approved the National Primary Care Policy, the Family Health Program and the Program of Community Health Agents. From there, the primary care network represents the main gateway for health institutions to users, through services offered by multi-professional teams. This network has a personnel structure consisting of: doctor, nurse, dentist, dentistry assistant or technician in dental hygiene, nursing assistant or technician and community health agents, and other professionals, depending on the epidemiological and institutional reality and health needs of the population[6].

Regarding the community health agent, this has the task of caring for the registration of households in the geographic region encompassed in a micro area and keeping these data updated; monitoring all families and individuals under their responsibility through home visits; permanent contact with the families, developing educational activities aimed at health promotion, disease prevention and follow-up

of people with health problems[6]. Based on the tasks assigned to community health agents, it is notable the extensive responsibility of this professional regarding the demands of the community. This professional must continuously improve in knowledge in order to understand the working process and the actions that should be carried out along with the family health team, so he may monitor and be resolute in the face of health problems of users.

Continued education, besides its educational dimension, should be seen as a management strategy with provocative potential of changes in daily services in its micro-policy, near the actual effects of healthcare practices in the lives of users, and as a process lived "at work, by the work and for the work"[6:39].

According to the National Primary Care Policy, the redirection of the care model clearly imposes the need for permanent transformation of the functioning of services and the work process of the teams, demanding greater analysis capacity, intervention and autonomy from his actors (workers, managers and users) for the establishment of transforming practices[6]. Thus, working with the population contingent of elderly patients with chronic diseases requires specific skills from health professionals, particularly from the community health agent, which has the function of making the exchange between community and health services, because this professional brings the information on community needs to the multidisciplinary team and also returns them to the population. The actions that the elderly require from community health agents is that they have specific knowledge about the field of aging, so that may meet their demands.

Based on the data here exposed, the following research question: which are the experiences of community health agents in the care of elderly affected by chronic diseases? To answer this question, the following objective was elaborated: to understand the experiences of community health agents in the care of elderly patients with chronic diseases.

Methods

Qualitative research carried out in a municipality of Rio Grande do Sul/Brazil, which has a population of 34,225 inhabitants, and among these, 3,589 (10.49%) are 60 years old or older than this age[7], that is, are elderly.

Data production occurred from June to August 2013 and participants were community health agents linked to the Basic Health Units that have the Family Health Strategy. The selection of participants was intentional, and respondents were selected by the researcher on the grounds that they had representative characteristics of the population and taking into account the importance they have in relation to the subject studied. According to the nature of the adopted methodology, interviews were suspended when the researchers identified the saturation of information, that is, when the data began to be repeated and did not add new elements to the collected content[8].

The inclusion criteria of the study participants were: be a Community Health Agent and be linked to a Family Health Strategy. As a means of obtaining the information, open interviews were used with a guiding question: talk about your experience in relation to the care of elderly patients with chronic diseases.

Following these procedures, 20 community health agents were interviewed. With the information arising from the interviews, data were organized and analyzed following the precepts of content analysis, which consisted of three stages: pre-analysis, where initial ideas are organized and systematized; exploration of the material, where coding is carried out; treatment of results, inference and interpretation where data are treated so as to be meaningful and valid[9]. Basically, the analysis identified the critical elements, grouped and categorized the reports according to their relevance for the research. To guarantee anonymity, subjects were nominated by the initial CHA, followed by a number, not necessarily in the order in which the interviews were conducted.

The study complied with the formal requirements contained in the national and international regulatory standards of research involving human beings.

Results

As for the characterization of the 20 Community Health Agents who participated in the study, 19 were female and one was male, with ages between 24 and 51 years. In relation to marital status, 13 were married, five were single, one was separate and one was divorced. With regard to schooling, 14 completed high school, three had completed superior education and three were enrolled in undergraduate university courses. The average income was one minimum wage and a half. In the period of data collection, the minimum wage in the country was R$ 678.00, corresponding to *US*$ 303.763. The time working in the function was between six months and 12 years. Data showed that the average number of families assisted by each community health agent was 180, ranging from 133 to 265 families. Regarding the number of elderly people assisted by each community health agent, it was found that the average was 64 elderly by professional, varying from 25 to 130 by geographic area covered.

After reading and rereading the content from interviews, one category of analysis emerged from the convergence of ideas. This concerns the practices established by community health agents in the care of elderly patients with one or more chronic diseases.

Practices established among community health agents and elderly patients with chronic disease

Community health agents, when questioned about the everyday experiences of work, especially with the elderly, reported that they experienced different difficulties. One concerned the resistance that the elderly had to make changes in lifestyle. Thus, the community health agents expressed that they faced problems to effectuate the guidelines on health education. They indicated the low level of education of the elderly as a factor that contributes to this because this inhibits the understanding and following the guidelines. This seems to directly influence the health and prevalence of chronic diseases in this population: *The greatest difficulty to pass the information is for them to adapt to modernity. They do not adapt. They are still in the old fashion. 'Ah, I will take some tea only, and I'll be fine.' So, until he understand that it is not only the medication, but that he has to follow a diet, until he accepts, it is difficult. It's been two months that we have been working on it* (CHA 2). *Sometimes it is not even an attempt of giving instruction. Ask them not to eat rice, potatoes and pasta and then you arrive there, and there is rice, potatoes and pasta in the table. 'Please, this will hurt you, it will hurt, it will make the disease worse'. Or ask them to use less salt, fat* (CHA 9). *I see illiteracy as a major aggravating when it comes to the elderly. It's what most affect my work and that we cannot do anything about* (CHA 11).

In addition to the resistance of adherence towards changing living habits for the elderly, it was also observed that the low educational level of this population affects also their understanding for the use of medications and knowledge about them. For example, misunderstanding about the types of drugs and the times to take them were reported and this may interfere with the health of older people and lead to a worse clinical outcome. So the participation of the family in the care for the elderly is of fundamental importance, including the moment when health professionals need to give guidance on drug therapy: *Most times they mix the drugs, then they insist ... 'It is for such a thing, it is for that thing.' I call here, talk to them (staff), they repeat ... 'No, this medication is for that ...' They feel that security, because they trust ...*(CHA 2). *So we have lots of trouble because the elderly take the wrong medication and the family does not care. The same with food. They eat correctly for a few days and then return to doing wrong again* (CHA 8). *We face problems because they do not accept, do not take medication, do not accept what the doctor says ...* (CHA 20).

Community health agents also found limitations in their practice with the elderly at the time to guide you about the importance of attending the health service because even if the agent is one of the members of the multidisciplinary team, a more

skilled care is done with the entire health team, which, in most cases, is allocated in health facilities: *What sets a limitation to me is they do not like the post. Their resistance to come to the doctor. So when sickness comes, they go to the hospital, do the treatment at the hospital, but to the post they do not want to come* (CHA 7). *The way I use to address something needs to be like playing, because when I start to say you have to go to the post they start to get a little reluctant and elusive, mad. It is very difficult to bring them to the post* (CHA 8).

Elderly patients with chronic diseases are those who are at risk of health deterioration and they are the group of users who should receive the greatest number of home visits. There was, in contrast, in the words of some professionals, a difficulty to the community health agent access some households of elderly frequently: *I can not visit all families, because I have to stay in the unit, at the front desk, it's a little tiring* (CHA 14). *I prioritize the demand "for yesterday." More professionals are needed. We have a demand for another three health agents in order to be able to cover the entire area, thoroughly. To make that visit per month* (CHA 6). *I have 185 families. Sometimes you can not do the job right. I can not make the visits every month because we have meetings, other events. There are families that it takes 2, 3 months, up to 4 to make their visit. So there's no way to follow that beautiful script because it never worked* (CHA 11).

In addition to the difficulties related to the guidelines for the elderly, community health agents reported facing obstacles when the elderly need attention that goes beyond the scope that the health staff can provide them and/or when they need to be inserted into specialized services. This brings limitations for the development of the work of community health agents: *I can not say I have difficulty. What I think is that there is much limitation on the network itself. Sometimes you need an extension of the network and you don't get it, you do not have access or is very time consuming. The condition worsens a lot because of that. But difficulty is not the word* (CHA 1). *We can not do much because, there is more missing beyond here, because it is not about the team here only. We work tirelessly to get an exam, a query, but they enter the queue of the Unified Health System and the problem is in the network* (CHA 9). *I went after the health surveillance, only I did not received any support. That I tell you ... you hit that wall there. So, as a health age you get frustrated because that time comes when you do not have a "follow". In fact you only cease the fire. You go home feeling anxious, incompetent because you can not do as you wanted it to be, how do you think to be right. So you breathe, go with the awareness of the part that you made, close the door of your house and leave the rest out. Because you end up getting involved* (CHA 6).

It was possible to identify in the lines of research participants that they developed the practice based on responsibility, commitment and understanding of the reality in which they lived. They recognized the limitations that they experienced, but felt powerless in the face of certain situations, as for its resoluteness, they depended on other services and/or other professionals. This is to qualify the practice, the socio-cultural context must be considered, there must be a network of coordinated health services fulfilling their role, as well as the professionals involved.

Discussion

It is understood that this study has limitations, since it is restricted to one municipality, which leads to a given reality. This is due, in part, to the research method adopted, which is concerned with a reality that can not be quantified and uses information arising from the subjectivity of participants[10]. However, it is considered that the results produced useful and valid information that may contribute to the health care policies, particularly focusing on the elderly. They may also guide health intervention measures aimed at this population group, which is in continued growth in the Brazilian contingent.

The practice of Community Health Agents with the elderly is experienced in different ways, in particular by considering the limitations or resistance presented by the elderly. One of the difficulties they pointed concerned barriers that older people themselves had, such as low capacity to assimilate guidelines, commonly due to reduced secular education, resistance to adhere to what is agreed in terms of changes in living habits and the correct use drug therapy.

Study of elderly patients with chronic diseases shows that those with no education had lower average quality of life when compared to the literate[11]. In addition, elderly people with low education tend not to accept the recommended diet and changing their lifestyle. When the number of morbidities is compared with the years of schooling, research showed that uneducated elderly have more than three morbidities, while those with more than eight years of study report not having diseases[11]. The level of education can be an important factor to obtain knowledge and, consequent, to care fro oneself, with adoption of healthier lifestyles.

Although professionals still rely on vertical educational practices, health education is coated as the main strategy for lifestyle changes in order to improve health conditions, weather individually or collectively. Health education values prior knowledge of the population and is anchored in scientific knowledge[12]. Different methods should be adopted and made available for the implementation of health education for the elderly, given the complexity of the aging process, coupled with the peculiarities of each individual such as beliefs, values, norms and ways of life. Thus, one should take into account the knowledge, culture and the environment in which the elderly are inserted when planning interventions for providing health education to this population[13].

The aging of the population makes the society to face different challenges in terms of health care and education. Elderly people who have social support and care from friends and family can self-manage their life and live independently. However, the higher prevalence of chronic diseases in this age group compromises the self-management of daily life and the control of these diseases, which makes health education difficult[14]. Furthermore, the implementation of educational programs for older people has faced resistance, due to the difficulty of these people to modify their lifestyle and adhere to treatment plans[14]. Thus, it was identified in this study that the low level of education of the elderly makes the work of Community Health Agents harder and these professionals must be prepared to develop strategies to deal with this public, improving the comprehensiveness of care actions.

In addition to the low level of education that hinders the understanding and implementation of the guidelines on chronic diseases of the elderly, one of the causes of non-adherence to drug therapy is their forgetfulness and also of those who administer their medicine and the refusal to take drugs[11]. The way to offer care is through educational practices that represent a potentiating instrument of care action. These can be developed through community groups[15].

The association between education, better quality of life and self-care has been discussed. Therefore, it is necessary to be aware of this fact and carry out health education, using accessible language. Similarly, in the preparation of posters, visual communication must be enhanced in order to reach the target audience. Still, loss of auditory and visual capacity may occur with the human aging process and this interferes with communication. In this perspective, it is possible to improve the interaction speaking facing the elderly and in a paused manner, so that the elderly may see the lips of the speaker[14].

Among the duties of Community Health Agents towards the elderly population, it was noted that these professionals should dedicate extra care with those who make use of more than one drug per day, guiding the elderly or their family to ask clearly readable prescriptions from the doctor, and with the necessary information regarding the use of the drug. In addition, Community Health Agents can help the elderly who can not read to divide the drugs and put them in packages, drawing the time that these must be swallowed. Also, they must guide them not adopting as reference the color and size of the pill, because these may change

according to the manufacturer laboratory[16].

The elderly who attend the primary care service has the opportunity to gain interventions of promotion, prevention and control of diseases, learning new care strategies, through guidance offered by the health team and through participation in community groups, with the possibility to be an active subject in the aging process. Thus, the health team can strengthen communication with the elderly when developing the ability to interpret verbal and non-verbal communication. Then, the health team will identify the actual needs of the public, being favored with facial expressions such as attention, smile and interest, strengthening the bond of affection, reciprocity and respect between staff and users. Clear communication and one that reduces conflicts between the health team and users facilitates the adherence to the treatment and harmonizes the elderly's relationship with the team[17].

Among the group of priorities that the Community Health Agent should follow were giving more attention and increasing the frequency of home visits to the elderly who have predisposing factors for disability and mortality, as risk of falling or occurrence of hospitalization in the past six months, presence diabetes *mellitus* and/or high blood pressure without monitoring, being bedridden or having difficulty to go to health services and those who are alone and have several chronic diseases[18].

Even with the difficulty reported by Community Health Agents to insert the elderly in the services they need, there is legislation that ensures comprehensive health care for the elderly, with assurance of universal and equal access. In addition, aspects related to hosting the elderly in health care services, in the use of the scheduling and appointment system and reference and counter reference, are also ensured[19].

In addition to the actions for the elderly, Community Health Agents reported experiencing moments of suffering due to the work they perform. Study with Community Health Agents shows similar experiences of psychological distress, when it reports dissatisfaction resulting from conflicts between team members and the conditions that the work impose on them, especially the overwhelming number of tasks[20]. Another problem comes from the fact that Community Health Agents create expectations, particularly at the beginning of their career in order to give resoluteness to the problems they find in their community and when facing its magnitude, they feel disappointed for not solving the demands[20].

Study participants experienced difficulties that may be extrinsic and intrinsic to their performance. Among the extrinsic constraints, there were the non-compliance of the guidelines by the elderly, the difficulties of access to the service and use of drugs and the large number of families to assist. Among the intrinsic, they mentioned the limitations of knowledge about certain needs, lack of autonomy and anxiety, developed when facing the unresolved situations and/or problems of the elderly.

Conclusion

The study made it possible to identify that, in the relationship lived with elderly, community health agents faced difficulties related to the transference of guidelines on chronic diseases and, very frequently, the non-adherence of the elderly public. This occurred due to several reasons: low education level of the elderly, difficulty in understanding the importance of attending health facilities and forgetfulness, which can be associated with the aging process of the human being.

In addition to the difficulties encountered with the elderly, community health agents also reported facing adversity to perform actions inherent to their work, such as excessive work demands, lack of professionals and thus do less home visits to those users who require greater attention. Tere is also the

difficulty to give continuation to specialized services when the elderly need care of greater complexity, when facing a situation of fragility, puts the community health agent often in professional conflict. In this scenario, it was observed that these professionals should improve their knowledge to facilitate contact and information exchange with the elderly, through health education that can be promoted by the nurse.

Collaborations

Leite MT participated in the project design, data analysis, article writing and final approval of the version. Dal Pai S participated in the project design, collection, analysis and interpretation of data and writing of the article. Hildebrandt LM e Silva LAA contributed to the relevant critical review of the content and final approval of the version to be published.

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