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FUNCTIONAL HEALTH LITERACY LEVEL AND BEHAVIOR IN THE HEALTH OF THE ELDERLY[1]

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ABSTRACT

Objective: to evaluate the level of functional health literacy in elderly people and to discuss its influence on the health behaviour of these people.

Method: a cross-sectional, exploratory-descriptive study, characterized as mixed research design, convergence model. Data collection was carried out between August and November 2016 and occurred in the homes of 175 residents in the inner cities of the State of Rio Grande do Sul (Brazil), classified as elderly by the application of the S-TOFHLA instrument, of which ten answered the open interview on health behaviour. The Pearson's chi-square test; Fisher's exact $\alpha = 5\%$ and $p \leq 0.05$; and thematic content analysis were used for data analysis.

Results: the functional health literacy level was inadequate in 39.4% of the elderly study participants. There was an association between functional health literacy and gender variables; age group; schooling and number of children ($p \leq 0.005$). The Health Behaviour category was subdivided into the subcategories: Role of the health professional, Family and friends support, Custom and subjectivity, with transversality4 of functional health literacy.

Conclusion: This study reiterated the importance of evaluating the level of functional health literacy in the overall care of the elderly person as a relevant initiative to adequately plan health actions with the aim to improve results in the production of care.

DESCRIPTORS: Aging. Literacy in Health. Health Behaviour. Health Promotion. Community Health Nursing.

NÍVEL DE LETRAMENTO FUNCIONAL EM SAÚDE E COMPORTAMENTO EM SAÚDE DE IDOSOS

RESUMO

Objetivo: avaliar o nível de letramento funcional em saúde de idosos e discutir sua influência no comportamento de saúde destes idosos.

Método: estudo transversal, exploratório-descritivo, caracterizado como desenho misto de pesquisa, modelo de convergência. A coleta de dados, realizada ente agosto e novembro de 2016, aconteceu nos domicílios de 175 residentes na zona urbana de município do interior do Estado do Rio Grande do Sul (Brasil), idosos por meio da aplicação do instrumento S-TOFHLA, destes, dez responderam a entrevista aberta sobre comportamento em saúde. Para análise dos dados foram utilizados, os testes qui quadrado de Pearson; exato de Fisher $\alpha=5\%$ e $p \leq 0,05$; e análise temática de conteúdo.

Resultados: o nível de letramento funcional em saúde demonstrou-se inadequado em 39,4% dos idosos. Houve associação entre o letramento funcional em saúde e as variáveis sexo; faixa etária; escolaridade e número de filhos ($p \leq 0,005$). A categoria Comportamento em saúde subdividiu-se nas subcategorias: Papel do profissional de saúde, Suporte familiar e de amigos, Costume e subjetividade, com transversalidade do letramento funcional em saúde.

Conclusão: este estudo reiterou a importância da avaliação do nível de letramento funcional em saúde na assistência global do idoso como iniciativa relevante para adequação do planejamento de ações e comportamentos em saúde, visando melhores resultados na produção do cuidado.

DESCRITORES: Envelhecimento. Alfabetização em saúde. Comportamento de saúde. Promoção da saúde. Enfermagem em saúde comunitária.

NIVEL DE ALFABETIZACIÓN FUNCIONAL EN SALUD: Y COMPORTAMIENTO EN SALUD DE IDOSOS

RESUMEN

Objetivo: evaluar el nivel de alfabetización funcional en salud de ancianos y discutir su influencia en el comportamiento de salud de estos ancianos.

Método: estudio transversal, exploratorio-descriptivo, caracterizado como diseño mixto de investigación, modelo de convergencia. La recolección de datos, realizada en agosto y noviembre de 2016, ocurrió en los domicilios de 175 residentes en la zona urbana de municipio del interior del Estado de Rio Grande do Sul (Brasil), ancianos por medio de la aplicación del instrumento S-TOFHLA, de éstos, diez respondieron la entrevista abierta sobre comportamiento en salud. Para el análisis de los datos se utilizaron, las pruebas qui cuadrado de Pearson; exacto de Fisher α=5% y p≤0,05; y el análisis temático de contenido.

Resultados: el nivel de alfabetización funcional en salud se demostró inadecuado en el 39,4% de los ancianos. Se observó asociación entre el fonograma funcional en salud y las variables sexo; grupo de edad; escolaridad y número de hijos (p≤0,005). La categoría Comportamiento en salud se subdividió en las subcategorías: Papel del profesional de salud, Apoyo familiar y de amigos, Costumbre y subjetividad, con transversalidad de Alfabetización funcional en salud.

Conclusión: este estudio reiteró la importancia de la evaluación del nivel de Alfabetización funcional en salud en la asistencia global del anciano como iniciativa relevante para adecuación de la planificación de acciones y comportamientos en salud, buscando mejores resultados en la producción del cuidado.

DESCRIPTORES: Envejecimiento. Alfabetización en salud. Comportamiento de la salud. Promoción de la salud. Enfermería en salud comunitaria.

INTRODUCTION

As a global reality, population aging, extends to the Brazilian reality and is accelerated and mainly due to a combination of sharp falls in fertility and birth rates and an increase in life expectancy.[1] This process is characterized by changes which can bring challenges to the health-disease dynamics in everyday life, which potentiates the idea of the need for an improved evaluation of specificities and understandings of the aging process in the context of contemporaneity. From the perspective of positive aging models, one of the challenges in establishing a broad response to the aging process is to seen in the disagreement with the purpose of many older approaches, based on outdated stereotypes. It is necessary to look for new social relations, as aging historically refers to processes of social inequalities.[3]

It is pertinent to understand that to equalize the dichotomies present in human relations, in the face of aging and the provision of health and care to the elderly, it is not necessary to do more than is already done, but to be able to guarantee access to the integrative services, focused on their real needs, and also recognizing the failures in professional-user communication. In this context, the evaluations and interventions carried out by the most distinct professional groups need to broaden the vision for health and care for the most varied forms of manifestations of potentialities and/or vulnerabilities.[4] In this context, functional health literacy (FHL) comes to light.

FHL is characterized by the process in which the individual is seen in activity, developing their writing and reading skills to perfection, or at least quite easily in the sense of becoming and/or remaining healthy; preventing and/or managing the disease.[5-6] The health literate being has the ability to understand different contents related to concepts and other subjects of daily life which reveals the state and condition that this individual (or group social) acquire after having appropriated writing and social practices.

"Health literacy does not concern the mechanical (though important) activity of deciphering codes, signs, and words, but rather engaging with practices of reading and writing in our social contexts."[8:65] It is expected that the individual in a continuous process of literacy will be able to read and understand textual genres of diverse subjects, including the health sciences.[6] Thus, the evaluation of FHL in the elderly population is considered important, since it has been identified by the World Health Organization through the Commission on Social Determinants of Health (CSDH), as one of the social determinants of health, denoting its importance in obtaining, understanding and apprehending health information and its application in decision making to improve or maintain the individual and collective health/illness status.[9]

Considering this premise, FHL can be an indicator for the reformulation of interventions, policies and practices of several health services, but its measurement should be well applied and based on reliable validation instruments, whose results offer adequate support and tools to reduce the health disparities attributed to low health literacy.[10-11]

From the exposed scenario, this study was developed with the objective of evaluating the level of FHL in elderly residents and discuss its influence on the health behaviour of these elderly people.

METHOD

A cross-sectional, exploratory and descriptive study, characterized as a mixed research design, in which the combination of quantitative and qualitative data follows the convergence model, which provides for the integration of data in the final analysis and discussion phase.[12]

The study was carried out with elderly residents in an inner city in the State of Rio Grande do Sul, in Brazil, from August to November 2016, and met the following established inclusion criteria: to be aged 60 or older, to be a resident in the urban perimeter of the municipality and to be literate. The participant selection was done through a home visit to all people aged 60 and over, living in the urban perimeter of the municipality. At the time of the visit, the tests of choice for the selection were: Mini Mental State Exam (MMSE) and Clock-Drawing Test (CDT) to evaluate the cognitive performance of the elderly; whisper test (Whisper Test) and Jaeger chart for auditory and optometric evaluation, respectively.[13]

Older people who did not have reading or writing skills (illiterate) and who had some cognitive, visual or auditory deficit were excluded because they were considered to be potent confounders of the study results. A sample of elderly people (n=175) was selected from the reference population (N=250) of elderly people living in the urban area. Acceptance was confirmed by signing the informed consent form.

The short version of the Short-TOFHLA Test of Functional Health Literacy in Adults, translated and applied in Brazil, was used for the FHL assessment.[14-15] The application of S-TOFHLA was performed by trained researchers and two community agents in the elderly's home, at a previously scheduled date and time. In order to characterize the participants, a questionnaire was utilized which was composed of social and demographic determinants (sex, age, schooling (years of study), occupation, income, marital status, number of children and with whom they reside), health (diabetes, hypertension, osteoarticular diseases (osteoporosis, osteoarthritis, rheumatoid arthritis), depression, comorbidities and lifestyles (use of alcohol and tobacco), use of medications and types).

Among the 175 elderly S-TOFHLA respondents, ten were randomly selected to participate in an individual interview, with open questions regarding health behaviour, with the intention of understanding the influence of FHL on the life of the elderly people under investigation. The number of ten participants followed the methodological technique of gradual inclusion, called gradual theoretical sampling, which predicts the approximate number of participants in the sense that if there is theoretical saturation the population will be constituted with fewer people, and if there is no saturation the population will be higher.[16] A recorder was used to record statements, and the elderly participants did not have any time limit to make their statements.

In the data analysis, the level of functional literacy was stratified according to the correct answers described in the classification of the scores.[14-15] The Pearson chi-square tests and exact of Fisher´s exact test at the level $\alpha=5\%$ and $p \leq 0.05$ were used in order to verify the association between the FHL and the socio-demographic and clinical variables. Data analysis was performed using the SPSS software (version 20.0). The sociodemographic and clinical characteristics are presented through descriptive statistics; the continuous variables are presented by mean and standard deviation, median, percentiles, maximum value and minimum value. What emerged from the interviews and composes the qualitative data was interpreted following the content analysis proposal.[17] Thus, considering the category of health behaviour, expressed by the elderly people in the interviews, significance units were abstracted and later grouped into themes which composed subcategories.

The research was approved by the Research Ethics Committee of the University of Passo Fundo (opinion 467.889; CAAE 22094513.4.0000.5342). In view of resolution no. 466 of December 12, 2012, CNS National Health Council, the citation of the statements of the elderly participants are referred to by the letter I (elderly) followed by Arabic number expressing the order of the statements.

RESULTS

Upon assessing the FHL level, 39.4% (n=69) of the 175 elderly study participants presented with an inadequate FHL level and 37.7% had a borderline FHL level. The average score in the overall FHL score was 57.31% (±17.549), according to table 1.

Table 1 - Distribution of functional health literacy in elderly in inadequate, borderline and adequate classifications. Severiano de Almeida, RS, Brazil, 2016. (n = 175)

Functional health literacy	*f*	%
Inadequate	69	39.4
Borderline	66	37.7
Adequate	40	22.9
Total	175	100

Note: the average score in the overall functional health literacy score (textual and numerical)=57.31% (±17,549)

According to the variables analyzed regarding the social and demographic determinants stratified by the FHL test, it was observed that the majority of the elderly participants were female, corresponding to 63.4% (n=111) of the sample. The majority was between 60 and 69 years of age, corresponding to 54.9% (n=96), with a mean age of 70.7 years (±7.64), and 58.3% (n=102) reported living alone. The majority of the elderly participants have a monthly income, 97.7% (n=171). Among these, 66.9% (n=117) have a monthly income of up to R$ 954. Among the surveyed elderly participants, 50.9% (n=89) reported having between one and four years of schooling; 66.3% (n=116) have up to three children; 70.3% (n=123) are married; 97.1% (n=170) are retired, and of these, four have another occupation, distributed among general services, agriculture and paid employment, according to table 2. The sociodemographic and clinical variables that showed association with FHL were age group; sex; origin; schooling and number of children with p value (≤0.05), according to the results described in table 2

Table 2 - Sociodemographic characteristics of the elderly participants of the study. Severiano de Almeida, RS, Brazil, 2016. (n=175)

Characteristics	Functional Health Literacy				p* value
	Total (N=175)	Inadequate (n=69)	Borderline (n=66)	Adequate (n=40)	
	n	n (%)	n (%)	n (%)	
Age - Average (SD)	70.73 (±7.64)				
Age group (in years)					0.018
60-69	96	27 (28.72%)	39 (41.49%)	28 (29.79%)	
70-79	52	26 (48.15%)	18 (33.33%)	10 (18.52%)	
80-89	27	16 (59.26%)	09 (33.33%)	02 (07.41%)	
Sex					0.046
Male	64	29 (45.31%)	27 (42.19%)	08 (12.5%)	
Female	111	40 (36.04%)	39 (35.13%)	32 (28.83%)	
Resides with somebody					0.369
Yes	73	25 (34.25%)	28 (36.36%)	20 (27.39%)	
No	102	44 (43.14%)	38 (37.25%)	20 (19.61%)	
Origin					0.011
Local	89	24 (26.97%)	42 (47.19%)	23 (25.84%)	
Other location	86	17 (19.77%)	27 (31.39%)	42 (48.84%)	
Monthly income					0.239
Yes	171	66 (38.60%)	66 (38.60%)	39 (22.80%)	
No	04	03 (75%)	00 (00.00%)	01 (25%)	
Income bracket					0.163
R$ 954,00	117	47 (40.17%)	44 (37.61%)	26 (22.22%)	
R$ 1.908,00	42	17 (40.48%)	18 (42.86%)	7 (16.66%)	
> R$ 1.908,00	12	02 (16.66%)	04 (33.33%)	06 (50%)	
Schooling (years)					0.003

1 - 4 years	89	46 (51.68%)	30 (33.71%)	13 (14.61%)	
5 - 8 years	66	29 (43.94%)	19 (28.79%)	18 (27.27%)	
More than 8 years	20	04 (20%)	07 (35%)	09 (45%)	
Number of children					0.034
Up to 3 children	116	37 (31.90%)	50 (43.10%)	29 (25%)	
Up to 5 children	33	14 (42.43%)	11 (33.33%)	08 (24.24%)	
More than 5 children	22	15 (68.18%)	05 (22.73%)	02 (9%)	
Marital status					0.480
Single	05	04 (80.00%)	00 (00.00%)	01(20.00%)	
Married	123	47 (38.21%)	46 (37.40%)	30 (24.39%)	
Widowed	36	16 (44.44%)	14 (38.89%)	06 (16.67%)	
Separated	11	02 (18.18%)	06 (54.55%)	03 (27.27%)	
Retired					0.153
Yes	170	65 (38.23%)	65 (38.23%)	40 (23.52%)	
No	05	04 (80.00%)	01 (20.00%)	00 (00.00%)	

Pearson's chi-square test and Fisher's exact test at 5%

Regarding the health condition of the elderly study participants, 52.6% (n=92) reported presenting arterial hypertension, among other morbidities. Diabetes was limited in association with FHL. A percentage of 6.3% (n=11) reported smoking, three participants reported being smokers for fifty years; 1.7% (n=3) reported drinking alcohol on a daily basis; 78.9% (n=138) use allopathic medication, 30.4% b (n=42) use two types of medications and the average amount of medication was 3.2 (±2.096) according to table 3.

Table 3 - Health conditions of the elderly study participants. Severiano de Almeida, RS, Brazil, 2016. (n = 175)

Health conditions	Total (N=175)	Functional Health Literacy Inadequate (n=69)	Borderline (n=66)	Adequate (n=40)	p* value
	n (±)	n (%)	n (%)	n (%)	
Diabetes					0.066
Yes	27	15 (55.55%)	10 (37.04%)	02 (7.41%)	
No	148	54 (36.49%)	56 (37.84%)	38 (25.67%)	
Hypertension					0.774
Yes	92	35 (38.04%)	34 (36.96%)	23 (25%)	
No	83	34 (40.96%)	32 (38.56%)	17 (20.48%)	
Osteoporosis					0.729
Yes	41	14 (34.15%)	17 (41.46%)	10 (24.39%)	
No	134	55 (41.04%)	49 (36.57%)	30 (22.39%)	
Rheumatoid arthritis					0.525
Yes	3	02 (66.67%)	01 (33.33%)	00 (00.00%)	
No	172	67 (38.95%)	65 (37.79%)	40 (23.26%)	
Depression					0.632
Yes	17	05 (29.41%)	08 (47.06%)	04 (23.53%)	
No	158	64 (40.51%)	58 (36.71%)	36 (22.78%)	

Smoker					0.390
Yes	11	04 (36.36%)	06 (54.55%)	01 (9.09%)	
No	164	65 (39.64%)	60 (36.58%)	39 (23.78%)	
Average amount of time (years)	42 (±11.225)				
Alcohol consumption					0.495
Yes	3	01 (33.33%)	02 (66.67%)	00 (00.00%)	
No	172	68 (39.53%)	64 (37.21%)	40 (23.26%)	
Average amount of time (years)	37.5 (±11.225)				
Medication use					0,191
Yes	138	55 (39.86%)	48 (34.78%)	35 (25.36%)	
No	37	14 (37.84%)	24 (64.86%)	05 (13.51%)	
Average use (daily)	3.20 (±2.096)				

Pearson's chi-square test and Fisher's exact test at 5%

The Health Behaviour category emerged from the content analysis and subcategories were printed to express the conditions to which the elderly study participants are exposed to: Role of the health professional; Family and friends support; Custom and subjectivity, shown in figure 1.

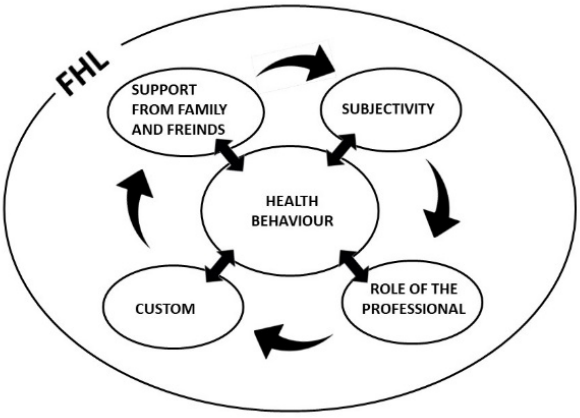

Figure 1 - Representation of the health behaviour category and the subcategories extracted from the interviews with the elderly study participants. Severiano de Almeida, RS, Brazil, 2016. (n=10)

FHL is identified as a determinant that makes it possible to maintain health status; to obtain the improvement of this or to problematize assumed behaviours, and is therefore understood as a transversal category to the health behaviour category and the subcategories that emerged from the interpretation of the information obtained from the participants.

In the present study, the limitation in this determinant is perceived by a significant percentage of the elderly population, with inadequate FHL (39.4%) and borderline FHL (37.7%), and this deficiency is based on the discussions provided by the interviews.

Role of the health professional

In this construction, it was possible to perceive the presence of the health professional as a guiding principle for instructions and prescriptions, as well as a tool for inducing practices and/or behaviours, according to the statements: [...] *I always observe and follow what practitioners recommend , because they are prepared for it and know what is best* (I1); [...] *I always follow the best which is the professional's guidance, because they know everything I need to improve my illness or the pain I am feeling* (I6).

For the elderly participants of this study, the form of communication exercised by the professional can lead to assertive health proposals or not, and is widely disseminated by the elderly in their positionings. However, communication for the elderly has been reported as sometimes difficult because of the words used by health professionals, which extrapolate their understanding, in addition to their illegible handwriting, which suggests deconstruction of equity advocated by the Brazilian Health System (SUS).

The relevance of this position is in the field of the urgency of clear communication between the professional and the user, reverberating in the capacity of the understanding of the elderly and potentializing the acceptance of the behaviours oriented and manifested in the construction of care. In this context, the elderly people position them-

selves: [...] *the handwriting, neither I or the pharmacist can understand the words, If there is no one to explain the things to me I am afraid of doing something wrong* (I2); [...] *sometimes, it is the doctor's own handwriting, but the pharmacists write it correctly, so it gets better* (I4); *[...] really, I cannot read what is written; there are a half a dozen scribbles* (I10); [...] *things are explained quickly, so I do not know where I'm going. It is difficult to understand* (I3); [...] *the lingo is difficult, sometimes we do not understand their terminology* (I8).

It is important to consider that the association between schooling and FHL was significant (p=0.003) in this study, strengthening the importance of the professional´s perception regarding the forms of communication, contained in verbal and written elements used in medical prescriptions and guidelines, norms and techniques attributed to expressions, exerting a positive factor in the construction of care for the elderly, above all, with respect to their individualities.

Support from family and friends

The elderly participants highlight the importance of support from family and friends related to sharing experiences, and the adoption of practices and decision making in the choice of alternatives for the maintenance and/or improvement of the health status of elderly people, as follows: *they (the children) tell me what to do and how I look for things. How to do* (I6); [...] *sometimes friends guide us to do something better* (I8).

Many of the elderly participants of this study assume the care position independently, while others inscribe actions based on orientations, opinions and sometimes even "orders" from family caregivers which can be seen in the discourse of the elderly participant´s interview: *I live alone, so I have to help myself. But there is always someone in the family to support us and see what is best* (I 2); [...] *my daughter helps a lot! She guides me a lot and also gives out to me too (laughs)* (I 4); [...] *I usually make the decision myself. But of course, we always have family, friends and we also have help in our city, if necessary* (I 7).

As expressed by the elderly participants, sometimes what is suggested by family and friends does not always match the health professional´s prescription, as can be seen in the following excerpt: [...] *sometimes I have to ask for help. I almost always ask for help ... sometimes I follow something different, but because I think it would be better, right, but I'll take the medication and whatever else I think of* [laughs] (I5).

It is important to emphasize that in the family context attributed to this study, the majority of the elderly people live alone, not that it was associated with FHL, however, the analysis of the origin was associated with FHL (p=0.011), allowing for an inference regarding the participation of the community in the care and management of the community, and the sharing of information that may be associated with this condition of naturalness in small communities, which is important information for the planning of home care (home visits); teamwork and the recognition of the assisted population.

Custom

The customs emerged in the speech of the elderly in this study as expressions of learning, family coexistence, and culture acquired in during the course of life, considering the dialogue on knowledge experienced by all. These customs involve self-care alternatives (use of herbal teas, herbal remedies, home-made practices, family experiences), meeting friends and volunteer work, understood as ways to feel good and remain healthy. One elderly participant expressed: [...] *I try to go out, drink tea, I use my medicinal herbs a lot* (I 6); *I drink my tea, which we learned to do in our gardening group and it makes me feel better than the medicine* (I 2); [...] *I participate in caritas* [...] *I then participate in the church which is also a good thing* [...] *we are kept busy and we learn too, there is the Italian choir group as well. These are all the things that we like to do* (I 3); [...] *I find voluntary work very rewarding, even for our health* [...] *the internal satisfaction, it´s very good for your health, you feel good* (I 7).

When the elderly participants show an infinity to some practices, they corroborate with the understanding that the development of the apprehension, understanding and attainment of meanings in health may be associated with the opportunities during the course of life. Rather than adhere to therapies that are in the field of professional guidance, these elderly people complement their practices with their own choices, derived from family experiences and collective learning. These choices may often differ from what is advocated, but are maintained by the elderly people, suggesting that they are part of a cultural identity, regardless of the punitive connection they may exert over time.

Thus, it is observed that some of the practices adopted as customs by the elderly participants of this study can be considered as potential arsenals in the search for biopsychosocial balance, while others may be constituted as health risks, which merit attention, since they refer to the possibility of causing

complications: *ah yes, I make my decisions. Sometimes even a little self-medication* [laughs], *home remedies* (I 7); [...] *I always compare the compositions, and if this one is almost the same as the other, I don´t need to take both of them, right? I remove one at the time* (I9); *we always use some old remedies of course, like home-made medicines* [...], *it is not only in the pharmacy, every herb has its purpose. We know there are several types of herbs that help* (I10).

Subjectivity

The perceptions of the elderly in relation to themselves reveal positions that can influence self-care and health promotion. Their pronouncements denote the characteristics of old age combined with subjectivity, revealing limitations that are exposed over time, which highlight forgetfulness, physical frailty and non-transmissible chronic diseases, their pronouncements also inscribe the care alternatives that they understand to be beneficial to maintain or improve the quality of life. Thus, their expressions accompany the threshold of subjectivity: [...] *I am a bit forgetful as well, that bothers me a lot. Sometimes it's hard. I'm forgetting things a lot* [...] (I2); [...] *I can´t walk for very long, I am hypertensive, so I do not have much disposition to run and walk* (I4); *I try to do physical exercises, pilates; I like crossword puzzles, I like watching a good movie. I get up early, I drink chimarrão tea. I like to chat with the wife, do things around the house* [...] (I10).

In the subjectivity of the elderly participants of this study, the presence of hypertension was identified among the non-transmissible chronic diseases. The chronic diseases reported by the elderly had no association with the FHL outcome, however, they support considerations regarding the relationships that health care teams can establish with individuals in the "aging" process.

The use of medications was indicated by more than 78% of the elderly participants of the study, fomenting the idea that care with prescription medicine, drug leaflets and information given to this population should take priority in the therapeutic approaches assumed by the health teams and the elderly population.

The statements, discourses and experiences of the elderly contribute to the understanding of how FHL behaves in the elderly person´s context. In addition to its association between sociodemographic and clinical variables, the FHL assessment leads to an understanding of the influence of FHL on the life of the elderly person and promotes self-perceived representation in their experiences and social relationships. The results expose the importance of creating care with cautious bases, reliable assessments and effective tools. This management nature (care pathways) can influence the health outcomes of the elderly in the communities, improving professional relationships and promoting health in its entirety.

DISCUSSION

In the construction of the data of this research it was possible to determine the level of inadequate FHL in a significant portion of the studied elderly population. However, the significant proportion of elderly people with a borderline FHL level must also be considered, which, together with the percentage of elderly people with an inadequate level, is close to 78% of the studied population. This shows that professional reflection on the overall assessment and regular planning is necessary given the ambiguous trend of borderline positioning in this context.

The inadequate FHL results corroborate with studies that also obtained inadequate FHL levels in elderly study participants in the proportion of 45%; 73.7% and 55% respectively, however the target population was elderly people diagnosed with diabetes.[18-20] It is important to note that the literature points to a decrease in the FHL score with advancing age, revealing the association between FHL and age mentioned as a variable associated with FHL in this study.[18-21] The association of schooling with FHL is in line with the results of studies in which the elderly participants, for the most part, reported between one and four years of schooling.[18,20]

The female population was prevalent in the studied sample, which is in line with other studies.[15,18-19] The feminization represented here may be associated with a social risk factor attributed to exclusion, processes of intense prejudice and/or disengagement. However, it may also represent a restructuring of the relational social space, constituting an important link for a family support network, reverberating the premise of sensitivity, zeal, attachment and cultivation of family traditions and customs.[22] These characteristics may serve for the construction of relevant and assertive therapeutic projects in the context of health literacy, considering that the gender variable was associated with FHL in this study, as well as in the literature.[20-21]

It was also identified that the majority of the elderly participants in this study live alone, however, the contribution of family members was a positive factor in the context of health literacy. The number of children, for example, presented an

association with FHL, as described in table 2, showing the familiarity of the family content in life that extends to the viability of therapeutic proposals and the maintenance of the physical and psychological integrity of the elderly person.[23]

The support from family and friends reveals the closeness that the interviewed elderly participants maintain with their social support networks. Many elderly people are able to make the necessary associations to maintain or improve their health by assuming independence for decision-making and behaviour. This inference subscribes to the maximum of the elderly person´s understanding of information and transmits a positive status for their self-care, revealing attachment for behaviours and personal tastes. Thus, there is a reinforcement for the FHL of elderly people to be considered as a predictive element for the sensitization of care and self-care and efficacy in prescription and adherence to treatment.[24-25]

Regarding the identified customs in this study, the use of complementary alternatives to maintain or improve health care was common among the elderly people, in particular the use of medicinal plants. Corroborating this finding, studies have observed this practice in more than 70% of the interviewed elderly population, mentioning the use of between 23 and 40 species of medicinal plants.[26-27] In this scenario, among the limitations mentioned by the elderly participants of this study, chronic conditions are present, with a predominance of arterial hypertension, in keeping with the research data in which 55.3% of the interviewed women referred to arterial hypertension, among other reported health problems.[22]

The complexity that can be evidenced in the process of living and aging are results of the experiences and the singularity in the life of the individuals. In this context, one can expect a more humanized and equitable reception for the elderly population from the presented premises. The appreciation of an acceptance based on equity, which considers subjectivity in this context, overcomes the fragmented view of health and meets the diverse needs that elderly people are exposed to on a daily basis.[28] The recognition of low FHL observed in this research and in some studies, suggests greater professional accountability, given the difficulties, often associated with this determinant, by the populations. The presence of the health professional becomes essential in this context of information exchange and communication.[4,25,29] Addressing FHL at the community level, occupying the spaces of the demands of families and communities, provides great potential for improving health knowledge, skills and behaviours, and in turn provides better health outcomes.[25,28,30] The FHL assessment of a population in the context in which they live, is essential to capture dynamics and synergies within communities in order to reflect social influences on users' knowledge, beliefs, cultures and health behaviours, as well as the interaction between users and professionals in the context of care, favoring the effectiveness of the adopted and recommended therapies.[25]

Regarding the nursing professionals' performance in care, a study evaluates that these health professionals underestimate the level of FHL of users, and fail to previously identify those who have inadequate or even borderline level FHL.[30] Based on the results of a study carried out with 65 users and 30 nurses, this study proposes that the deficiency in the assessment contributes to generalized health problems, including high hospitalization rates, as well as precarious indexes of health outcomes, as well as highlighting the promotion of recurrent hospital readmissions of users from the communities.[30] In nursing care of the elderly, it is important for the nurse to know the life of the elderly person, the environment, experiences, singularities and particularities and, therefore, carry out the planning of strategies that can contribute to the demands of the elderly person under study, and be committed to the prior identification of dissonances between users and health professionals.[4,31] Therefore, it is imperative to "construct innovative and interactive forms of nursing management and care."[32:8]

From this perspective, the study identifies the elderly person´s insufficiency in understanding therapeutic prescriptions. Among the 227 elderly people interviewed, 51.1% presented insufficient understanding regarding medication, and the authors concluded that it is extremely necessary to plan strategies to increase the quality of the information and orientation given to the elderly person in order to ensure adherence and, consequently, compliance.[33] It is pertinent to highlight a study in which the participants highlighted several difficulties in the consultations that negatively impacted on their health experiences and the conditions to adopt healthy behaviours such as; communication difficulties, dialogue and information exchange

FHL plays an important role in the health promotion of populations, and is intrinsically associated with health information and the health behaviour of users. This scenario refers to the importance of

understanding the need for continuous monitoring of this public in order to achieve satisfactory health outcomes.[35-36] Thus, in order to increase the effects of health promotion, health professionals can aim to increase the health literacy levels of its target populations, thus obtaining better results and a more equal distribution of health indexes, as recommended by health care workers.

Considering that health promotion together with an adequate level of FHL, results in the appropriation of meanings in health in its genuine roots, with differentiated knowledge and with a favourable condition of the indexes recommended in health, the sample size of this study is considered a limitation and further studies with larger samples are recommended.

CONCLUSION

The FHL assessment among the elderly people in this study showed a higher prevalence of inadequate FHL levels, followed by borderline levels highlighting the need for preventive care in health care networks in relation to health literacy. There was association between the FHL and the age group variables; sex; origin; schooling and number of children. These findings suggest a relationship between the FHL level and the health behaviour of the elderly person, highlighting the need for interactions between professionals and users that respect this singularity, as well as adequate forms of communication in therapeutic practices. It also reflects on the relationships to which the elderly users are exposed to in relation to family and community attitudes and customs, as well as the forms of family planning and behaviour among individuals of the same community, by virtue of the management of care and self-care. Thus, experiences and coexistences between the elderly population and their social networks can highlight therapeutic proposals that can be assumed. This consideration expresses respect for the subjectivities of the elderly, guiding actions of a managerial, educational and preventive nature in the primary health care network.

However, it is inferred that the insufficiency of studies in the context of FHL in the elderly person can lead to iniquities related to the subject, excluding the evaluation of this determinant in health from the service agenda and underestimating its importance in the community context. FHL must be considered as a determinant that highlights important social and clinical characteristics when it is well evaluated and properly planned by health professionals. The recognition of this tool in health care can guide lists and flowcharts of the services, predicting its adequacy to the needs of the assisted populations.

REFERENCES

1. World Health Organization. World report on ageing and health. Geneva: WHO; 2015.
2. Mendonça JMB. O seguro-cuidado como uma alternativa de atenção às pessoas idosas dependentes. Geriatr Gerontol Aging [Internet]. 2015 [cited 2016 Aug 15]; 9(4):162-6. Available from: https://sbgg.org.br//wp-content/uploads/2014/10/1450709733_GG_v9n4.pdf
3. Nóbrega PRC. Reflexões teóricas sobre o cotidiano e a geografia no envelhecimento humano. Estud Interdiscipl Envelhec [Internet]. 2015 [cited 2016 Aug 26]; 20(3):865-81. Available from: http://seer.ufrgs.br/RevEnvelhecer/article/view/49487/36692
4. Willis CD, Saul JE, Bitz J, Pompu K, Best A, Jackson B. Improving organizational capacity to address health literacy in public health: a rapid realist review. Public Health. [Internet]. 2014 [cited 2017 Jan 23]; 128(6):515-24. Available from: https://doi.org/10.1016/j.puhe.2014.01.014
5. Moraes KL, Brasil VV, Oliveira GF, Cordeiro JABL, Silva AMTC, Boaventura RP, et al. Functional health literacy and knowledge of renal patients on predialytic treatment. Rev Bras Enferm [Internet]. 2017 [cited 2017 Feb 13]; 70(1):147-53. Available from: http://dx.doi.org/10.1590/0034-7167-2015-0169
6. Faria LC, Silveira VL. Letramento funcional em saúde: análise de material educativo em saúde bucal. E-scrita. Rev Curso de Letras da Uniabeu Nilópolis [Internet]. 2015 [cited 2016 Out 23]; 6(1):50-61. Available from: http://revista.uniabeu.edu.br/index.php/RE/article/view/1715/pdf_332
7. Passamai MPB, Sampaio HAC, Dias AMI, Cabral LA. Letramento funcional em saúde: reflexões e conceitos. Interface - Comunic., Saude, Educ. [Internet]. 2012 [cited 2016 Oct 23]; 16(41):301-14. Available from: http://www.scielo.br/pdf/icse/v16n41/aop2812.pdf
8. Barcelos AMF. Letramento emocional no ensino de línguas. In: Toldo C, Sturm L, organizadores. Letramento: práticas de leitura e escrita. Campinas (SP): Pontes Editores; 2015.
9. Commission on Social Determinants of Health - CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva (CH): WHO; 2008.
10. Collins SA, Currie LM, Bakken S, Vawdrey DK, Stone PW. Health literacy screening instruments for eHealth applications: a systematic review. J Biomed Informatics [Internet]. 2012 [cited 2016 Oct 22]; 45(3):598-607. Available from: https://doi.org/10.1016/j.jbi.2012.04.001

11. Institute of Medicine. Health literacy: improving health, health systems, and health policy around the world: workshop summary. Washington (DC): The National Academies Press; 2013.

12. Creswell JW, Clark VLP. Pesquisa de Métodos Mistos. 2ª ed. Porto Alegre (RS): Penso; 2013.

13. Ministério da Saúde (BR), Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Envelhecimento e saúde da pessoa idosa. Cadernos de Atenção Básica, n. 19. Brasília (DF): Ministério da Saúde; 2006.

14. Baker DW, Williams MV, Parker RM, Gazmararian JA, Nurss J. Development of a brief test to measure functional health literacy. Patient Educ Couns [Internet]. 1999 [cited 2016 Oct 23]; 38(1):33-42. Available from: https://doi.org/10.1016/S0738-3991(98)00116-5

15. Carthery-Goulart MT, Anghinah R, Areza-Fegyveres R, Bahia VS, Brucki SMD, Damin A et al. Performance of a Brazilian population on the test of functional health literacy in adults. Rev Saúde Pública [Internet]. 2009 Aug [cited 2017 Sep 01]; 43(4):631-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102009000400009&lng=en

16. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saúde Pública [Internet]. 2011 [cited 2016 Out 22]; 27(2):389-94. Available from: http://www.scielo.br/pdf/csp/v27n2/20.pdf

17. Bardin L. Análise de conteúdo. São Paulo (SP): Edições 70 – Brasil; 2011.

18. Souza JG, Apolinario D, Magaldi RM, Busse AL, Campora F, Jacob-Filho W. Functional health literacy and glycaemic control in older adults with type 2 diabetes: a cross-sectional study. BMJ Open [Internet]. 2014 [cited 2016 Oct 22]; 4(2):e004180. Available from: https://bmjopen.bmj.com/content/4/2/e004180

19. Santos MIPO, Portella MR. Condições do letramento funcional em saúde de um grupo de idosos diabéticos. Rev Bras Enferm [Internet]. 2016 Feb [cited 2017 Feb 13]; 69(1):156-64. Available from: http://dx.doi.org/10.1590/0034-7167.2016690121i

20. Federman AD, Wolf M, Sofianou A, Wilson EA, Martynenko M, Halm EA, et al. The association of health literacy with illness and medication beliefs among older adults with asthma. Patient Educ Couns [Internet]. 2013 Aug [cited 2016 Aug 15]; 92(2):273-8. Available from: https://doi.org/10.1016/j.pec.2013.02.013

21. Kobayashi LC, Wardle J, Wolf MS, von Wagner C. Cognitive function and health literacy decline in a cohort of aging english adults. J Gen Intern Med [Internet]. 2015 [cited 2016 Oct 22]; 30(7):958-64. Available from: http://dx.doi.org/10.1007/s11606-015-3206-9

22. Almeida AV, Mafra SCT, Silva EP, Kanso S. A Feminização da Velhice: em foco as características socioeconômicas, pessoais e familiares das idosas e o risco social. Textos & Contextos (Porto Alegre) [Internet]. 2015 [cited 2016 Aug 26]; 14(1):115-31. Available from: http://dx.doi.org/10.15448/1677-9509.2015.1.19830

23. Reis LA, Trad LAB. Suporte familiar ao idoso com comprometimento da funcionalidade: a perspectiva da família. Rev Psicol: Teor Prática [Internet]. 2015 [cited 2016 Out 23]; 17(3):28-41. Available from: http://dx.doi.org/10.15348/1980-6906/psicologia.v17n3p28-41.

24. Ramos PMG. Alfabetização e letramento: um estudo em contraponto. Grau Zero Rev Crítica Cultural [Internet]. 2015 [cited 2016 Oct 22]; 3(2):29-58. Available from: http://revistas.uneb.br/index.php/grauzero/article/view/3307

25. Guzys D, Kenny A, Dickson-Swift V, Threlkeld G. A critical review of population health literacy assessment. BMC Public Health [Internet]. 2015 [cited 2016 Aug 15]; 15(1):215. Available from: https://doi.org/10.1186/s12889-015-1551-6

26. Silva AB, Araújo CRF, Mariz SR, Meneses AB, Coutinho MS, Alves RBS. O uso de plantas medicinais por idosos usuários de uma unidade básica de saúde da família. Rev Enferm UFPE [Internet]. 2015 [cited 2016 Oct 22]; 9(Suppl. 3):7636-43. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/6358/pdf_7680

27. Ângelo T, Ribeiro CC. Utilização de plantas medicinais e medicamentos fitoterápicos por idosos. C&D Rev Eletr FAINOR [Internet]. 2014 [cited 2016 Aug 15]; 7(1):18-31. Available from: http://srv02.fainor.com.br/revista/index.php/memorias/article/view/246/188

28. Lopes AS, Vilar RLA, Melo RHV, França RCS. O acolhimento na Atenção Básica em saúde: relações de reciprocidade entre trabalhadores e usuários. Saúde Debate [Internet]. 2015 Mar [cited 2017 Feb 13]; 39(104):114-23. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042015000100114&lng=en

29. Smith SG, O'Conor R, Curtis LM, Waite K, Deary IJ, Paasche-Orlow M, et al. Low health literacy predicts decline in physical function among older adults: findings from the LitCog cohort study. J Epidemiol Community Health [Internet]. 2015 May [cited 2016 Aug 03]; 69(5):474-80. Available from: https://doi.org/10.1136/jech-2014-204915

30. Dickens C, Lambert BL, Cromwell T, Piano MR. Nurse overestimation of patients' health literacy. J Health Commun [Internet]. 2013 [cited 2016 Out 23]; 18(Suppl 1):62-9. Available from: https://doi.org/10.1080/10810730.2013.825670

31. Mendes A, Ponte K, Farias M. Cuidados de enfermagem para adesão, por idosos, de hábitos saudáveis de vida,

com base na Teoria da Promoção da Saúde. Rev Kairós: Gerontol [Internet]. 2015 [cited 2016 Oct 22]; 18(4):269-87. Available from: https://revistas.pucsp.br/index.php/kairos/article/view/29408

32. Silva SS, Assis MMA, Santos AM. Enfermeira como protagonista do gerenciamento do cuidado na Estratégia Saúde da Família: diferentes olhares analisadores. Texto Contexto Enferm [Internet]. 2017 [cited 2017 Oct 29]; 26(3):e1090016. Available from: http://dx.doi.org/10.1590/0104-07072017001090016
33. Pinto IVL, Reis AMM, Almeida-Brasil CC, Silveira MR, Lima MG, Ceccato MGB. Avaliação da compreensão da farmacoterapia entre idosos atendidos na Atenção Primária à Saúde de Belo Horizonte, MG, Brasil. Ciênc Saúde Coletiva [Internet]. 2016 [cited 2016 Oct 23]; 21(11):3469-81. Available from: https://doi.org/10.1590/1413-812320152111.19812015
34. Easton P, Entwistle VA, Williams B. How the stigma of low literacy can impair patient-professional spoken interactions and affect health: insights from a qualitative investigation. BMC Health Serv Res [Internet].2013 [cited 2016 Aug 15]; 13(1):319. Available from: http://www.biomedcentral.com/1472-6963/13/319
35. Geboers B, Brainard JS, Loke YK, Jansen CJM, Salter C, Reijneveld SA et al. The association of health literacy with adherence in older adults, and its role in interventions: a systematic meta-review. BMC Public Health [Internet]. 2015 [cited 2016 Aug 15]; 15(1):903. Available from: https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-015-2251-y
36. Santos MIPO, Portella MR, Scortegagna HM, Santos PCS. Letramento funcional em saúde na perspectiva da Enfermagem Gerontológica: revisão integrativa da literatura. Rev Bras Geriatr Gerontol [Internet]. 2015 Sep [cited 2017 Sep 02]; 18(3):651-64. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1809-98232015000300651&lng=en

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