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Community health workers caring for dependent elderly people

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Abstract *Community Health Workers (CHWs) are a link between Family Health Strategy (FHS) professionals and the community. This study aims to analyze health care professionals' perceptions and health management about CHWs' role in caring for dependent elderly people. A qualitative study was carried out, from a hermeneutic-dialectic perspective, with 38 professionals working in elderly people's health in cities in the five regions of Brazil. The results identified CHWs as facilitators of access to elderly people dependent on the health care network, gaps in continuing education and the reduced number of these professionals to meet the demand in primary care. Respondents attributed great importance to CHW's performance, valued their participation in FHS, but pointed out a lack of knowledge and difficulties to supply the adequate amount in health care services and in assistance of elderly people with dependence and family. It is concluded that health professionals and managers consider CHWs to be a great workforce and essential to the dependent elderly people and their caregivers. The number of CHWs is insufficient in relation to FHS, and there is a lack of training to deal with various types of dependence.*
Key words *Community health worker, Family health strategy, Health personnel, Frail elderly, Qualitative research*

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Introduction

Community health workers (CHWs) are workers at the Brazilian Unified Health System (SUS – *Sistema Único de Saúde*) who started their activities in the Brazilian National Program of Community Health Workers (PNACS - *Programa Nacional de Agentes Comunitários de Saúde*), which, after a year, became known as the Community Health Workers Program (PACS - *Programa de Agentes Comunitários de Saúde*)[1]. The profession was regulated in 2002 and its duties are provided for in Ordinance 2.4361 of September 2017, which approves the new Brazilian National Policy for Primary Care (PNAB - *Política Nacional de Atenção Básica*)[1,2].

PNACS started in the late 1980s, inspired by successful experiences in some states in northeast Brazil, the Federal District and São Paulo[3]. People from underserved communities, especially women, were assigned to assist in promoting health in their respective territories. CHWs strengthened the community's connection to health services and supported disadvantaged populations, as is the case with similar programs in other countries[4,5].

The Family Health Program (FHP), later Family Health Strategy (FHS), started to add CHW functions both in Basic Health Units (BHU) and in Family Health teams (FHSt). Among its attributions, the link between the demands of community and health services located in its area of emphasis stands out[6,7].

In health systems in several countries, there are workers whose role is similar to that of Brazilian CHW. Despite the different names, the term Community Health Workers identifies them in the international literature[4,5,8]. Regardless the countries of origin, these professionals show common traits, playing a strategic role with populations in rural areas, remote or in vulnerable situations. Its importance is recognized in the dialogue with the community, strengthening and consolidating health programs in different countries[4,8].

In South American countries, except Uruguay, professionals who resemble Brazilian CHW are official members of multidisciplinary teams, working for remuneration or voluntarily[5]. Portugal, France, Spain, England, United States, Canada, India, Kenya, Uganda, Ghana, and South Africa also include these professionals[4,8,9], who work with a pre-established number of families, on a defined geographical basis[10].

In Brazil, in 2017, the new PNAB[2] suppressed the minimum number of CHW per team, in contrast to the previous standard of four CHW per team, and there may be up to one CHW per team. Additionally, it also excluded from the text the forecast of the workload of up to eight hours/week for training these professionals[2].

According to the education and health promotion principles, CHWs are professionals who live with the singularities of families, knowing the living conditions and social relationships in communities[11,12]. Among its functions, participating in territory mapping, family registration and home visits allows to know the community reality and identify populations at risk[13].

As the population's life expectancy and aging grew, assistance and social challenges were addressed to CHWs. Demographic, epidemiological and health changes have resulted in the expansion of chronic and complex diseases, which make elderly people increasingly fragile and dependent, demanding more organized and resolved health care networks[12].

Indeed, increased longevity requires involvement of the entire FHSt in elder care. In this regard, the longitudinal contact and proximity of CHWs to homes express a potent space for carrying out care, especially for dependent elderly people[14].

It is believed that the guidelines in force at PNAB that reduced the number of CHWs per team may compromise care coverage of families, in addition to weakening the continuing education and training actions of CHWs. This makes it difficult to meet the population's needs, including dependent elderly people, who require articulate and resolute attention. In this context, CHWs play a strategic role in view of their proximity to families in the territory. However, there is a gap in scientific production on the relevant CHWs' role with dependent elderly people, which justifies focusing, in this investigation, health professionals' and managers' perspectives on CHWs' actions and roles with the frail elderly population.

Given the above, this article aims to analyze primary care and health management professionals' perceptions in about CHWs' role in caring for dependent elderly people.

Methods

A qualitative study was carried out with support in hermeneutics-dialectics. An understanding of the problem was sought, taking into account objective, subjective aspects, beliefs and meanings of managers and health professionals in relation to CHWs' role in the context of care for dependent elderly people and their families.

Hermeneutics-dialectics, as a theoretical-methodological lens, makes it possible to establish a reflective process[15], to understand the communication between people and their connections with the environment. In this perspective, everyday life and common sense are elements of investigation. Languages permeate the experiences and interactions instruments that lead to understanding the characteristics of the universe under investigation[16]. A researcher does not use personal conceptions, which makes it possible to read the meanings that emerge from the reflective movement.

By associating hermeneutics and dialectics[17], consensus and dissent lead to a broader world view, allowing research to deepen in context and reveal the multiple phases of a complex reality permeated by values, beliefs and subjectivities[18,19]. This combination of methods synthesizes comprehensive and critical processes, because the same reason that understands, clarifies and gathers, also challenges, dissociates and criticizes[15].

The contributions of this approach to understanding the particularities and concepts attributed to CHWs' performance with elderly people by respondents was verified with support in experiences, conflicts, experiences and interlocutions maintained in the professional and community scope.

Data collection took place from June to September 2019, in eight cities in the five regions of Brazil: Araranguá, Brasília, Fortaleza, Manaus, Porto Alegre, Belo Horizonte, Rio de Janeiro, and Teresina.

Thirty-eight professionals from primary care and health management participated, 22 of whom were female and 16 were male, with an average age of 43 years, who worked in the elderly people's health field in the eight cities, with the following training: physicians (8), nurses (18), social workers (3), physical educator (1), physiotherapist (1), dentists (2), neuropsychologist (1), biologist (1), nursing technician (1), pedagogue (1) and CHW (1).

Health professionals active, for at least a year, were invited in BHU and in municipal programs that support elderly people and their families were included. As managers, those responsible for the bodies that coordinate the elderly people's health in those cities were invited, such as health departments or managers of specific programs. In general, study participants had specializations, previous experiences or continuing education courses that enabled them to work in the context of elderly' health. The study excluded those who were on vacation, away from work or who missed work on the day of collection.

For the sample composition, professionals and managers were identified at BHU and at the municipal health departments of the respective cities, who were invited in person or by telephone to participate in the interviews. Interviews were conducted at the participants' workplaces by experienced researchers. Therefore, the sample was carried out intentionally, which is demonstrated by cities in the Table 1.

Semi-structured interviews were directed to each type of professional, with questions that started addressing identification data and length of experience in service. They went deeper to identify interviewees' perceptions of elderly people with social, physical, mental and cognitive dependence, facilities and difficulties to welcome, accompany or refer elderly people and their families with different types of dependence, and initiatives to support elderly people and families.

The interview questions were prepared by the researchers who worked together in the investigation, who participated in the local teams, carried out the interviews with permission of audio recording and were transcribed in full. Notes recorded in the field diary also supported data collection, which ended from the principle of saturation[20], when new ideas related to the topic under discussion no longer emerged.

In line with the presuppositions of hermeneutics-dialectics, the three steps recommended by Minayo[17] – ordering, classification and final data analysis were followed. Ordering includes transcribing interviews, reading empirical material and organizing the contents that emerge from the text in sets of meanings. Classifying the indicators denotes the elaboration and grouping of the sets of meanings in specific themes of the object of study. Analysis consisted of creating an organization flowchart to visualize the themes.

Although the interview script did not include specific questions about CHWs' role in the context of dependent elderly people' health, the focus of analysis in this article fell on the 14 statements of managers and 18 of health professionals

Table 1. Distribution of the number of participants by city, Brazil, 2020.

Cities	Professionals	Managers
Araranguá – SC	5	4
Belo Horizonte – MG	2	4
Brasília – DF	2	1
Fortaleza – CE	2	2
Manaus – AM	2	2
Porto Alegre – RS	2	1
Rio de Janeiro – RJ	5	1
Teresina – PI	2	1
Toatl	22	16

Source: Own authorship (2020).

who deal with this subject. Thus, given frequency and relevance, data made the study's objective emerge. The material, after being organized and analyzed, was presented in two themes.

Data were interpreted in the light of hermeneutics-dialectics[15,17], the literature on CHWs' role and approaches related to elderly people's health[2,3,21]. At the end, the research team synthesized the findings, dialoguing with the identified themes and comparing them to the theoretical-methodological framework, to the objectives and assumptions previously established.

To protect participants' identities, we chose to name them by means of letters and numbers. Letters HP refer to health professional and letter M refers to manager. The numbers correspond to the number of participants, such as, for example, HP1 means health professional number 1, M1 is manager 1, and so on.

This article is part of a study entitled *Estudo situacional dos idosos dependentes que residem com suas famílias visando a subsidiar uma política de atenção e de apoio aos cuidadores*, coordinated by a team belonging to the Department of Studies on Violence and Health Jorge Careli of the Brazilian National School of Public Health, *Fundação Oswaldo Cruz*. The project was approved by the Research Ethics Committee of *Fundação Oswaldo Cruz*.

Results and discussion

Health professionals' perceptions, be they of care or management, about CHWs' performance, expressed in the interviews, were mapped and synthesized, converging to the formulation of two thematic categories: "CHWs as facilitators of access to elderly people dependent on the health care network" and "Gaps in continuing education of CHWs on assistance to dependent elderly people".

CHWs as facilitators of access to elderly people dependent on the health care network

The approximation of CHWs with the community in which they operate and reside facilitates the knowledge of these professionals regarding families' social and health problems. In this logic, CHWs' praxis occurs in the capillarity of the first level of health care, materializing in easy access to elderly people and their families, in involvement with the family dynamics of elderly people, establishing formation of bonds, a 'bridge'. This dynamic goes beyond permeability with residents, as it also stems from knowledge of the ethical and safety codes that govern the territory in which they operate[22].

[...] *it is the job of CHWs to play this role very well* [...], *as a bridge.* (HP1, Rio de Janeiro)

Health workers are fundamental because they are within the territory, they know where all elderly people are. We [health professionals] *registered these elderly people, made this stratification* [...], *so they know who these people are, they know the reality of each family and where they are* [...]. (M1, Fortaleza)

[...] *health workers always accompany people so they don't go alone* [...], *I've done it alone* [...]. *As a matter of security in the area, we don't do it alone* [...]. (HP3, Porto Alegre)

This theme attests that the CHW is seen as a bridge between health professionals, the service and the assisted community. This idea of *bridge*, referred to frequently by participants, refers to *link, chain* and *bond*[23]. This perception occurs based on health care model reorientation that assumes the understanding of territory as a *living space*, where people demonstrate singularities, ways of living and socio-cultural arrangements to face illnesses[6].

In participants' statements, the importance of home care performed by health teams with CHWs emerges, establishing itself as a point of care in the health care network and supporting the concept of home visit (HV) as a means to carry out care centered on singularities and contexts of life[24]. It is worth expressing that the realization of HV strengthens the elderly people' sense of belonging to health services.

Health workers indicate who is most in need, and we select which elder needs to be visited. At most, we make six visits in the morning. We take turns regarding visits [...] (HP7, Teresina)

[...] *during the visit that health workers make, they talk and drink tea. This is not wasting time. This is paying attention to that elder, he or she feels important* [...]. *Health workers are coming to my house, the nurse is coming to my house to see me* [...]. *I think it's important, elderly people feel valued* [...] (HP6, Porto Alegre)

It is important to point out teaching-service integration, reiterating SUS as a "practice scenario" essential to training, highlighting the mediation of CHWs in academic pathways and in the constitution of intersectoriality, with access of dependent elderly people to the multidisciplinary actions of health services[25].

[...] *we have two trainee students in embracement and another health worker that is intended for the professional on duty. So, if you have a serious problem and the family comes, you will be treated on the same day.* (HP7, Teresina)

[...] *here we have many students, so they* [CHWs] *take students from physiotherapy, take students from the pharmacy,* [...] *take professionals to talk to these elderly people and end up becoming a cooperative group.* [...] *they talk, ask questions* [...]. (M4, Fortaleza)

In the perspective of approaching health system users, CHWs act as articulators in FHS. Most of them, coming from communities, show socio-cultural characteristics that bring them closer to users, in addition to allowing contextualization of the problems in the territory[26].

Still in the sense of getting closer to the community, CHWs embrace, listen and monitor elderly people in their homes, offering greater comfort and seeking to resolve the demands[27].

Litzelman et al.[28] report results in emergency care and hospitalization decrease in the state of Indiana, United States of America, where elderly people participate in discussions and decisions about their care with local CHWs, at home, through care planning. This shows the importance of bringing this professional closer to health system users. The study highlights the need for a strategy to increase the number of countries with this same target, as pointed out by the World Health Organization, by establishing programmatic and financial recommendations for programs that include the figure of CHWs[29].

Like India, CHWs establish a link between community leaders and those of religious organizations for health care performance, favoring access for underserved and remote communities across the country to primary care. In this perspective, this action provides changes in health-related behavior, with repercussions on the expansion of health care for these populations, as well as the positive impact on health across India[30].

Australian researchers have observed, from examples of successful government programs in low and middle income countries, that CHWs are effective. Thus, they decided to assess the scope, the value of this type of program in Australia and the challenges in integrating these workers into the health system. They verified the relevance of their performance in improving equity and access of the less favored population to Primary Health Care (PHC), facilitating access to health services and information, which becomes even more important considering the growing number of chronic diseases[31].

From the perspective of healthcare and management professionals, CHWs' performance offers an improvement in health conditions and advances in the actions recommended in PNAB. Thus, the interlocution of these workers with the community is seen as a positive aspect in conditions related to communication and health education.

CHWs' role refers to important aspects in the context of the health of dependent elderly people, since it increases the uptake of this population to access primary care (active search), enables risk stratification, the identification of diseases and brings the demands of elderly people to BHUs[32].

Not every "gather" of dependent elderly people' health needs contains a resolving outcome; often, it can become repressed due to SUS organizational processes, such as regulation, and the obstacles to overcome the complexity levels of health care[27].

It is a demand that is often dormant in the territory [...] *CHWs know this, but they do not always have instruments to take care of this situation*. (M1, Fortaleza)

In contrast, there are difficulties with reducing the number of CHWs per team[2], which implies fragmentation and incompleteness of care for dependent elderly people, family and or caregiver[33]. Facts of this nature were identified in the statements of professionals from Araranguá and Belo Horizonte:

[...] *our primary care unit has little staff to reach elderly people too, which would be ideal. I liked it a lot when we had more CHWs* [...]. *In this situation, we have one worker per team, there is no way* [...]. (M2, Araranguá)

[...] *now, we have three CHWs. Our area is huge, there are 40 thousand people* [laughs] [...]. *So, there is no way for CHWs to visit all families* [...]. (HP1, Belo Horizonte)

The reduction in the number of workers per team came into force with the new PNAB in 2017. This legal determination weakens the daily assistance coverage of CHWs in their territories, compromising compliance with the home visit agenda, moment when health problems and dependent elderly people's needs are raised. From then on, CHWs schedule appointments and consultations with the professionals of their teams, who, in turn, make referrals and referrals to specialized health levels.

The relationships of proximity and dialogue maintained by CHWs and professionals in care and management, in an attempt to mediate and bring elderly people and family members closer to health services, try to offer greater resolution to aspects that are often not revealed within of dependent elderly people' homes and families.

Many caregivers, as they are alone and do not have the support of other family members or neighbors, see CHWs as a support that enables the search for care, obtaining medication or, simply, a friendly ear to relieve the suffering and limitations of elderly people or their own.

The creation of *El libro Blanco de la Dependência*, in Spain, in 2004, it exemplifies the ample care for dependent elderly people, considering the integral health of this population within health care network. Thus, it establishes several axes of action and highlights the support to elderly people and caregivers at home with a form of respect, protection, comfort and improvement of quality of life and health[34,35]. PACS can seek inspiration in this strategy to act in the direction of a more comprehensive care for these families, based on the support of public policies and a training of CHWs directed to elderly people's health.

Gaps in continuing education of CHWs on assistance to dependent elderly people

In professionals' statements, there was an understanding of the desire to have, in their teams, qualified CHWs, holders of knowledge and skill to use means in health education, favoring their performance with dependent elderly people.

The objective [...] *would be to enable CHWs to perform more adequately during a home visit for a dependent elder, both in terms of attention to conditions that may compromise elderly's and caregiver's health. So, with more appropriate information, with identification of situations* [...] *CHWs can collaborate and improve the performance of the team at home.* (M2, Fortaleza)

Studies[22,36] state that CHWs' practices are based on welcoming and qualified listening, which strengthens the relationship with elderly people and, remember, that CHWs' performance in caring for the elderly population comes from the Brazilian National Health Policy for Elderly people (*Política Nacional de Saúde da Pessoa Idosa*) guidelines. Among other guidelines, this policy values the training and education of SUS professionals to work with this population, which brings value to CHWs' work, contributing to training these professionals regarding aging.

Silva et al.[37] and Medeiros et al.[38] point out that the challenges surrounding care for dependent elderly people and social inequalities in health amplify situations of vulnerability. In this regard, participants join forces to alleviate this dependence and neglected care, promoting health actions in line with the purposes of active aging.

[...] *we made a sample of the initiatives that we have at the unit. One of the things that CHWs are doing is a group that works* [...] *in a square nearby. We tried to make a group of elderly people inside the unit, they didn't come* [...]. *Then, they started doing in the square and started to gather elderly people.* (M1, Fortaleza)

Rahmawate and Bajorek[39] explore CHWs' role in a program to support hypertensive elderly people living in a rural community in Indonesia. These professionals stood out as "health care guardians". After being trained, they assisted in hypertension monitoring, supported professionals of a health unit in blood pressure measurement, guidance on physical activity and healthy eating. Elderly people and health professionals have evidenced many health benefits for those assisted by CHWs' work, in addition to the feeling of protection and support from peers.

There is an alignment of the actions of Brazilian CHWs described by professionals and managers with the principles of integrality and intersectoriality[40], prioritizing the dependence of elderly people, which supports the interviewees' statements:

[...] *we have some fixed guidelines. Among them are bedridden patients, most of whom are elder. CHWs also bring cases to us, and we also take them to CHWs to actively search for an elder, to find out if any elder is in a situation of social vulnerability* [...] (HP2, Belo Horizonte)

[...] *during home visits, when we go to CHWs, we try to give a lot of guidance to the family* [...] *about bedridden patients and about patients who do not have this restriction* [...] (HP1, Porto Alegre)

Permanent health education is crucial to offer quality actions. This should be based on knowledge of the political guidelines, statutes and manuals[41,42], in addition to legal and ethical provisions. Melo et al.[43] affirm that, when understanding SUS as a training space, PNAB 2011 predicted that up to 8 hours/week of FHS professionals would be used for training activities, continuing education, matrix support and on call in the emergency network. This wording did not last in the current PNAB[1,2].

PNAB reformulation weakens continuing education for the greater purpose, which is the reconfiguration of praxis in search of solutions to the problems that emanate from it. Thus, it is also perceived, as discontinuity, a lower valuation of continuing education, a key part for the work in primary care (PC)[42]. A manager's statement shows how important it is to internalize the concepts of continuing education in health work:

[...] *several professionals and CHWs were trained in integrative practices* [...] *and they fell asleep in the network. They took the course and stood still, they weren't doing their practices* [...] (M2, Fortaleza)

Filgueiras and Silva[26] point out that these professionals facilitate approximation between health services and community, as well as helping to expand access to health information and practices. Studies[4,44] demonstrate that CHWs' work can be effective in improving population's health in low, middle and high income countries. However, CHWs cannot reach their full potential to act in the community, with different populations and age groups, without a continuous training process.

Understanding the importance of CHW's performance by health managers and professionals, in the perspective of dialectics, comes from the comparative act, when they confront actions and attributions of each one. In this regard, CHWs recognize the need for a broader and deeper training that privileges elderly people's health and dependency, so that they can act with greater property and offer more resolution to this population.

The Guidelines for Training CHW in Care Lines[21] are based on axes for providing a care service that is more directed to the target audience, proposing to meet regional, local demands and health priorities. They choose imperative points to be effective in PHC, this being the level that orders and coordinates care in the intricacies of the health care network.

CHW's training in elderly people' health is seen by participants as an essential strategy so that CHWs can act based on the Brazilian health policies that regulate the organization of health services and improvement of the population's living and health conditions. In such a way, it will be able to act in health care promotion for elderly people through articulation between actions of education and mediation in health, principles of popular education, problematization of reality and active participation in the community. Therefore, CHWs will be able to increasingly encourage emancipatory relationships between the different health professionals working with the elderly population, developing integrated actions in PC teams and strengthening the care coordination principles.

Final considerations

The findings reveal a positive view and relevance of CHWs' work in health teams, especially in FHSt. Health actions aimed at elderly people, especially dependents, need CHWs' performance, as these professionals represent a link between the family, the FHSt and other services in the municipal health network.

Participants' statements demonstrate that thanks to CHWs' intensive adherence to the families registered in their assigned areas, FHSt have a permanent vision for this clientele, especially the elderly, fragile and dependent population.

As they are closer to families, CHWs identify dependent elderly people's needs and facilitate their access to the health care network. Professionals recognize, however, that the reduced number of CHWs per team as well as the compromise of the workload destined to the training and continuing education of these workers are responsible for the fragility of the assistance coverage's work. This compromises the entire line of care for dependent elderly people, either in PC or in accessing other levels of health care.

Another evidence reported by participants on CHWs' performance in their territories refers to the support provided to informal caregivers. They recognize in them a support that enables the search for care, obtaining medication or an attentive listening capable of relieving the suffering and limitations of elderly people and caregivers.

Concerning CHWs' performance in relation to fragile elderly people, participants pointed out a need for changes in Brazilian legislation that guarantee the expansion of the number of CHWs per team. Another demand is the allocation of hours for training and qualification of these human resources to work with the elderly population, with emphasis on dependents.

The aged population, which increases the number of older elderly people, CHWs are of great importance and need to be increasingly prepared to meet the basic needs and assistance demands of this clientele.

This investigation also contributes in the public health field in the sense of filling gaps in knowledge in the national and international scientific literature regarding the object of study analyzed given the lack of publications on CHWs' role caring for dependent elderly people, which gives a character of originality to the text.

As a limitation, it was found that, although the idea that CHWs are considered important in caring for elderly people in PHC emerged from the statements, the interview questions did not address this specific topic, which may have suppressed the opinion of some participants on this theme. On the other hand, many professionals and managers interviewed, from most cities, issued relevant opinions on CHWs' performance regarding elderly people's health.

Collaborations

CCP Brasil, RM Silva, IC Bezerra, LJES Vieira, MLF Figueiredo, FRVF Castro, FFSN Queiroz and MRTF Capelo declare that they participated in the preparation of the manuscript and that they publicly assume responsibility for its content.

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