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ACTION OF COMMUNITY HEALTH AGENTS FOR PERSONS DEPENDING ON CARE AS A RESULT OF CHRONIC DISEASE

Rafaela Ghiraldi Rocha*
Hayzza Juliana Lopes Velasco**
Anderson da Silva Rêgo***
Marcelle Paiano****
Cremilde Aparecida Trindade Radovanovic*****
Maria Aparecida Salci******

ABSTRACT

The objective of this study was to know the health actions carried out by community health Agents to families of persons dependent on care. The study is qualitative in nature, carried out with 21 professionals that integrate teams of the family health strategy of a small municipality, located in the Northwest of the State of Paraná. For the collection of data using semi-structured interview that were subjected to content analysis on thematic mode. It was bond-related facilities built with the assisted families, equity of care and responsiveness of users the work of community health Agents. Pointed out difficulties in assistance as low schooling, fear caused by the presence of drug addiction in the areas of scope and workload. In organizational issue the inefficiency of specialized services, lack of transport to the visits and materials needed for the work considered as factors that impede the achievement of a more adequate assistance. It is concluded that the community health Agents, accompanying the families care for dependents, have your work interfered negatively by the difficulties encountered in everyday life, which need to be improvised on a daily basis so that the assistance is provided.

Keywords: Community health workers. Health education. Primary health care. Chronic disease. Family.

INTRODUCTION

The chronic diseases (NCD) are a group morbidities, which have special characteristics, and may have a gradual onset with long duration or uncertain, which had with multiple causes and in general, the treatments involve changes of lifestyle, in a process of continuous care[1]. The high cause of morbidity and mortality among CNCDs has been a subject of intense national and international debate, mainly due to the burden that these diseases cause on the health system of all countries, posing a great challenge to managers[1-3].

In Brazil, diagnosis, treatment and follow - up d the NCD, even with the Unified Health System (SUS) free, universal, aimed at completeness and fairness in its infancy, require a high individual costs due to complications, the which contributes to the increase of the personal costs with the treatment, generating socioeconomic impact on the families[4].

Moreover, in recent years, there has been a major expansion of Primary Health Care (PHC), Because of the implementation of the Family Health Strategy (ESF), which emerged with the aim of overcoming the model centered on curing diseases and individualized medical care. The ESF aims to promote health through basic actions that allow the incorporation of programmatic procedures in a more comprehensive way, focused on promoting the quality of life and intervention of the factors that put it at risk, allowing a more accurate identification and better monitoring of the individuals with health promotion activities, prevention, recovery, rehabilitation of diseases and maintaining the health of the enrolled community[5,6].

Currently, Brazil has approximately 41,238 E SF teams, made up of professional's physicians, nurses, technicians or nursing auxiliaries and community health agents (CHA) who work in the Basic Health Units (PHUs) in the communities[6]. Although the ACS are still a number that is far from desired, some 263 thousand professionals and its significant importance for increasing access to basic health services, by enhancing the production of links with the community and the users of these services, producing and assisting in the change of focus for the construction of a new model of health care[7,8].

With regard to the ACS 's work in relation to families who care for the family member with care dependence due to complications of CNCD, their

*Nurse. Resident, ResidencyProgram in Management of Nursing Services of the StateUniversity of Londrina - UEL. Londrina (PR), Brazil. E-mail: rafaela.gr_@hotmail.com. ORCID: https://orcid.org/0000-0001-9299-3422
**Nurse.Santa Casa de Misericórdia. Maringá (PR), Brasil. E-mail: hayzza_juliana@hotmail.com.ORCID:https://orcid.org/0000-0001-8559-4589
***Nurse, Doctoral student, Undergraduate Program in Nursing, State University of Maringá (UEM). Maringá (PR), Brazil. E-mail: anderson.dsre@hotmail.com. ORCID: http://orcid.org/0000-0002-0988-5728
****Nurse, PhD in Nursing, Profess Undergraduate/Graduate Nursing Course, UEM. Maringá (PR), Brazil. E-mail: mpaiano@uem.br. ORCID: http://orcid.org/0000-0002-7597-784X
*****Nurse, PhD in Health Sciences, Profess Undergraduate/Graduate Nursing Course, UEM. Maringá (PR), Brazil. E-mail: kikanovic2010@hotmail.com. ORCID: http://orcid.org/0000-0001-9825-3062
******Nurse, PhD in Nursing, Profess Undergraduate/Graduate Nursing Course, UEM. Maringá (PR), Brazil. E-mail: masalci@uem.br. ORCID: http://orcid.org/0000-0002-6386-1962

activities need to be evidenced so that new care strategies can be created or improved in search of better care considering its most important aspects, especially the suspicion of disease prevention and health promotion activities at home stock or holiday, On-individual or collective, ACS operates in the production of care, and transmitter of health information that happens to families[6] .

The work of the ACS also provides familiarity with the experience, which hardly be shared with the other members who constitute the ESF team. In this context, this approach allows the reception and listening to the health needs of people with ACS role as health educator and co r responsible for the production of care in individual aspect and community social context[9].

Care practices should design the family in their private and domestic social space, respecting the movement and complexity of family relationships. To the health professional who inserted in the dynamics of the family life, it is an attitude of respect and appreciation of the peculiar characteristics of that human conviviality. The integral approach is part of home care because it involves multiple factors in the family health - illness process, influencing caregiving[10].

In the literature, there are studies that deal with the role of CHW in relation to their obligations as a professional member of the FHT teams; is a question of families who experience care for a family member who needs care[10]. In this context, this study aimed to evaluate the health actions performed by ACS is the families of people dependent on care.

METHODOLOGY

This is a descriptive, qualitative study carried out in a small municipality, located in the northwest of the state of Paraná, which has a population of approximately 35 thousand inhabitants. Regarding the APS infrastructure, this municipality has nine UBS and seven ESF teams, which provide coverage to 24,150inhabitants[11].

The participants of the study were the CHA who are part of the ESF teams of the reference municipality, which at the time of data collection were 55 professionals, making up the population coverage of 95.31%[11]. The intentional sampling process selected the informants. The professionals invited personally by the researchers and informed about voluntary participation and that met the inclusion criteria, which were more than years of work in function and operates in urban areas. Were excluded are those with less than one year of operation as ACS and those who served in rural areas.

21 ACS was part of the study. After the selection of the participants, they scheduled for individual interviews in the workplace, respecting the availability of the agenda, in the day and at the appropriate time. Data collection carried out between September and November 2016, through magazines then opened, and saved in electronic audio devices, after the s s participant's consent, with an average duration of 40 minutes.

The interviews guided by the following initial question: How do you track people and families who are dependent on care for a DCNT? In order to achieve the goal of the study, other questions been asked: How do you accompany adult and elderly people experiencing CNCDs who are dependent on care because of this condition? How is your monitoring routine for adults and elderly people dependent on care derived from CNCDs? Report the difficulties of this job to you.

In addition, to support the data collection, a research diary used in which, at the end of each interview, aspects that could not be captured by audio recording, researcher insights, and other information relevant to the analysis were recorded. For the collection of demographic data, specific questions asked, through a questionnaire drawn up by researchers, such: age, sex, schooling, time spent in health services.

The composition of the data of the study resulted in 190 pages of document Word® and the organization given by the analysis of content, thematic modality. In operational terms, the analysis followed the first two steps: establishing the Corpus and preparing the material[12]. Therefore, the researchers made inferences and interpretations guided by the theoretical collection, in which collective alignment sought to find the logic that structures the individual's discourse, style, and atypical elements[12].

The development of the study followed the guidelines determined by Resolution 466/2012 of the National Health Council. The municipal health department approved the study after the approval of the Standing Committee on Ethics in Research with Human Beings, opinion No. 1,666,364. All participants signed the Informed Consent Form of the participants, in two ways. In order to keep the interviewees anonymous, sequential numbers used for the individual identification of each ACS.

RESULTS

Characterization of study participants: ACS

The study included 21 ACS, s is Wed 20 were female; eight had the Complete High School. The age ranged from 22 to 57 years and the duration of the function ranged from one to six years, as shown in Table 1.

Table 1. Characterization of Community Health Agents. Paraná, Brazil, 2016

ACS	Sex	Age	Education	Time of operation
1	Female	25	Incomplete Higher Education	1 year
2	Female	38	Complete high school	3 years
3	Female	42	Complete high school	5 years
4	Female	57	Complete primary education	2 years
5	Female	28	Full Higher Education	1 year
6	Female	39	Incomplete Higher Education	4 years
7	Female	43	Complete primary education	5 years
8	Female	47	Complete primary education	3 years
9	Female	35	Complete high school	2 years
10	Female	55	Complete primary education	6 years
11	Male	53	Complete primary education	3 years
12	Female	23	Incomplete Higher Education	1 year
13	Female	36	Complete high school	1 year
14	Female	22	Incomplete Higher Education	1 year
15	Female	45	Complete primary education	3 years
16	Female	48	Continuing Education	3 years
17	Female	32	Complete high school	2 years
18	Female	35	Complete high school	1 year
19	Female	33	Complete high school	4 years
20	Female	27	Complete high school	2 years
21	Female	24	Incomplete Higher Education	1 year

Source: Survey data, 2016.

For the presentation of the results after the characterization of the ACS, the data resulting from the analysispresented in two categories: "Legal of ACS for dependent persons care" and "Difficulties of ACS in the care of dependent people care".

ACS actions for people dependent on care

According to the study participants, the main planning activity done by all teams of SF and the dependent care people was conducting home visits (VD) monthly. They recognized that this planning made for all the families in your area d and scope, the absence of an organization's specific needs for people dependent care, observed in the following report:

> At least once a month, at the very least, we must have a home visit for all patients in our coverage area [...] (ACS-13).

> In fact, we have to visit the whole area, 100%, once a month [...] (ACS-02).

However, in their individual schedules, some CHWs adjusted their work routine and performed DV more frequently to patients who needed them most. However, the ACS in conjunction defined this adjustment with the other team professionals, who did not follow specific protocol, but there was flexibility to meet the demands of the service and the needs of people, as stated:

> When you need it, we try to go there once a week or every other day. According they ask or nurse asks us to go [...] (ACS-14).

> [...] in the case of people who have chronic illness or who are bedridden s, we end up going more often. We go through or they call us when they need something, like dressing material, medication [...] (ACS-20).

During home visits, the activities performed by ACS varied, such as delivery of material for dressing, follow-up of possible blood pressure tests andgreater attention to care for the use of medications, in order to verify if people are using correctly. These actions and the RV were good in communication between the ACS and other health professionals involved in the care and consequently the ACS instructed on the necessary information's referring to the use of health services.

> If you have to go home for some other reason, to check pressure, we have to go back, or to accompany the doctor or nurse ... because if you are pregnant, child or bedridden, we have to go through more times (ACS-01).

> Follow-up done once a month. The patient who needs the most comes back to us once a week or every fifteen days. The necessities would be dressings, a worsening of the clinical picture and use of medication (ACS-09).

> We go to their house; we ask if they are taking the right

medication, if they are measuring the glucose. Who cannot come here to get the doctor passes the prescription and the gent and leads to them [...] (ACS-12).

They have patients who are elderly and cannot read it is difficult for them to take the medication. Therefore, we do tabs or schedules for them to be remembering to take. Even in these, we spend more often in the house to see if they are taking the right medication [...] (ACS-03).

In addition, the ACS also accompanied other ESF professionals in case of VD performs action for procedures such as bandages, blood pressure measurement, blood glucose and regular consultations.

We take prescription [...] sometimes a bandage or an injury that is coming out; we spend for girls and take them. We will together do this part of family care and guidance (ACS-17).

I always take the help to check the pressure, carry out the guidance on medicines, and care (ACS-06)

In the follow-up to families who care for family relationship dependent on care due to NCDs, the ACS reported that the link developed with users was an aspect that brought satisfaction in the development of their work. Thisconsidered the key for easy access, in the sense of openness of the community to their work, as well as to the acceptance of care.

I know most people [...] I find it easy to get into houses, I talk to most patients. Sometimes I am passing the street, I stop to talk and I end up doing a visit right there (ACS-3).

They serve us well; do not have that resistance, like to receive visitors. This is so cool! (ACS-19).

Difficulties of CHW in care for people dependent on care

The difficulty s reported for the accomplishment of its activities was the fact that the family members expect that the work carried out by ACS will meet all the needs of the user, for example, accountability for the search and delivery of revenues, of drugs and results of examinations. In addition, was a charge by the family members regarding the service provided by the ACS, imposing responsibilities that, in most cases, were not applicable to these professionals.

There is a relative that who does not care for the sick person, who is not there, there we have to do it. I will not let you die; I will not leave you without medication! Therefore, we do (ACS-13).

The biggest difficulty I have is that the children do not take responsibility. I keep waiting and nobody comes [...]. Sometimes the child lives in the party, but does not take responsibility, stays waiting for us (ACS-18).

The fact that some families did not receive them in their homes also seen by some CHAs as a difficulty in the execution of their work, because they were not able to accompany these people.

[...] we get there and sometimes the family does not understand. We want the best personand superfamily have to get too, and there is that anguish of waiting for that partnership (ACS-02).

Another difficulty presented by the interviewees was the illiteracy of some users and caregivers, which made self-care impossible, requiring greater attention from the professionals involved.

Many people who care for these bedbugs do not know m reading and writing. Moreover, them depends more of my attention. Because I need to go and pack the recipe, and I do not have all that time [...] (ACS-17).

Still as a difficulty to perform their functions with the families of people dependent on care, the ACS pointed out the existence of flaws in the dynamics developed by the multidisciplinary team. These weaknesses related to the absence or lack of commitment of other professionals of the team with these users. In addition, of the rotation of the medical professional in the team, seen by the ACS as a difficulty in the formation of the bond that ended up repercussing in the quality of the assistance offered.

[...] depends on the nurses, two doctors. Here it is not for a doctor, it does not create a bond, and it is a negative point that ends up disrupting the service (ACS-7).

Sometimes you have to measure pressure and the nurse cannot go. It is no use doing my part if the team does not help because I cannot measure pressure or check for diabetes (ACS-15).

[...] I think the follow-up should be better, but I think I should have more attention from the FHP physicians, because bedridden patients require more attention [...] (ACS-19).

Another aspect considered as a difficulty in this performance was the inefficiency of specialized services. This condition generated low resolution and inability to feelings and frustration at p art of the ACS, as they felt responsible for the care and monitoring of users.

There are things that are not within our reach. Moreover, I find that a difficulty. It is difficult ... And some are resources that do not depend on us, like the case of specialized consultations. It takes time, it does not, and

> sometimes it gets bad for us, the family does not understand (ACS-2).
>
> Because it is a service that depends on other people, you cannot solve everything. I go to the patient's home and pass the problem to the staff. However, when there is no solution, I feel like I have done nothing. In addition, it is not all we can solve. Nevertheless, I get annoyed (ACS-17).
>
> In addition, the lack of adequate transportation noted, since access in some areas of coverage was difficult due to the distance that had to covered on foot by these professionals
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> Displacement is not easy. My area is not close. It is difficult because of the distance; I think it is the greatest difficulty [...] (ACS-3).
>
> On a rainy day, we will go a little later, and if we cannot get a car, we will go with our own car [...] (ACS-3).
>
> The presence of drug users in the coverage areas pointed out as a significant factor that hinders the work of the ACS, as it generated fear and insecurity in these professionals, as they travel through the streets of the neighborhood, as expressed in the statements:
>
> There is a lot of drug dealing in the neighborhood. It is more difficult because we are at risk of life (ACS-5).
>
> [...] there are some patients that stay where they have enough drugs, then we are afraid to visit alone (ACS-14).

DISCUSSION

The results presented in this study point to the flexibilization of the service actions performed by the ACS, which do not have service protocols, but are organized in a way to serve the users according to the demand. The National Policy of Basic Attention[6] recommends that all CHAs should carry out RVs to families in their coverage area for at least once a month. The ESF establishes home health care in order to assist those who need continuous care, which also functions as a local diagnostic tool, allowing the programming of actions from the reality, in an equitable way, enabling equity in care[13].

In this aspect, the importance of ACS in identifying health needs and demands of the population observed, since it is the main intermediary between health services and users. Nevertheless, the ACS enhances the integrality of care, reinforcing adherence and allowing the building of the bond by listening and guidance to those served (14).

However, it observed in this study that the function of ACS goes beyond those assigned to them. D have shown that they have a high responsibility for assisted families , since they are considered co- responsible for families , as a consequence of the creation of the link, and because of this relationship, users find in ACS a channel of communication with the health service, it to make complaints, seek information or resolve situations.

This condition in which the ACS's found, demands to him the accomplishment of several papers, what justifies even more the feeling of commitment of these professionals towards the population. The establishment of the link between ACS and family care of dependents allows ACS to gather information that would hardly s reported to other team members[9]. However, this relationship also brings overburden to the ACS, such as charges for assignments that are not the responsibility of the professional category.

The VD allow cognitive per living conditions, housing of families, the relationships in the home environment, the health and approximate users d the health service, which can assist in the planning and direction of actions aimed at health promotion and strengthening of self-care, considering the reality of people's lives, their needs and limits, as well as the integration of the multiprofessional team's perspective. The RVs performed by different types of health professionals allow the integration of knowledge in the face of different local realities, which enables individual and quality care[13].

In addition, DV is an important tool for investigating health conditions and the need for guidelines, such as drug treatment, which reported by the interviewees as a difficulty in performing care. The importance of ACS in verifying the correct use of medications becomes relevant for the prevention of adverse events and the greater adherence to the therapeutic plan. In a study conducted in Rio de Janeiro, 22.5% of the interviewees stopped taking their medications and 38% did not request m guidelines from health professionals[15]. Thus, it pointed out the relevance of the ACS as a health educator because it is the member of the team immersed in popular knowledge, supported by scientific knowledge, and inserting the multidisciplinary team in care, according to the health needs of the population[16].

It is worth noting that despite the positive aspects of creating the link between ACS and health service users as a facilitator of dialogue, the community finds in them a way to collect certain services that are not part of their function, often placing the agent in an abusive situation, which ends up doing what would be the task of the family itself[17].

In the same way, a study[18] carried out with ACS in Santa Catarina; families express as they have

confidence in ACS, because of the respect and exercised approach in home care, further increasing the bond. However, the life of the professional's ends up exposed to the people they accompany and the disconnection between the personal and professional reality is difficult, culminating in physical and emotional overloads.

The RV activity encompasses challenges, uncertainties, and surprises in its realization. The need for professionals to relate to the public within the private home space can lead to a denial of care provided, making the work of the CHA more difficult, in addition to situations of change of address, wrong addresses, among others that directly interfere in the realization of activities with the population[13] evidenced in the results of this study.

Regarding the educational level, the low level of education of individuals, especially those dependent on care, difficulty and much access to information as the understanding of the mechanisms of disease and treatment, which is a challenge for the multidisciplinary team health care, including ACS, which carries out household monitoring, identifies risks, and is more concerned with these persons[19].

The failures in organizational dynamics, pointed out by the ACS, identified as a difficulty in carrying out their work. In addition, this hiatus culminates in difficulties in developing bond and adequate assistance. The existence of an integrated multiprofessional work, in a perspective of horizontal relationship, combined with the sharing of the construction of the therapeutic project and the possibility of renewing the practice of the professionals involved, transforms the actions according to the local reality, strengthening the practices of self - care , and thus constitute the real potential of RV[13] .

The lack of resources hinders working conditions and the functioning of health services, which contributes to the worker having trouble and unforeseen in the development of his activities, requiring unplanned actions and dealing with physical, cognitive and logistics[13]. In order to serve the population, the professionals unfold, since the solution of the problems goes beyond their own efforts.

The difficulties encountered by the professionals in the VD not only involve the confrontation of the diseases, but also, situations inherent to the social and cultural context in which the family lives and the ACS itself, being necessary to respect the limits of the professionals and to assume referrals to the problems through alternatives and relational actions[11]. However, the roles assumed by the CHA in the team and the proximity to the assisted families favor situations that cause moral distress, which is associated with responsibility for errors and fragilities on the part of CHAs. Thus, it is noted that this professional does not take up the role in the decisions of the multidisciplinary team, which would contribute to the improvement of quality of service[6, 20].

The study is limited to the population studied, because it belongs to a small municipality, but it covers the reality of several localities in the country .Nevertheless, the findings of this study may contribute to a greater reflection of the FHT team on the process of work organization, especially the nursing professional who is responsible for supervising the services performed by the ACS in improving the quality of care through care practices quality of life of both the population and the worker.

CONCLUSION

It identified that CHWs plan and executes care and follow-up for adults and elderly caregivers resulting from NCDs along with the other ESF staff working with this population. Generally, this attention realized through the monthly RVs; however, it can occur in a shorter period of time, which depends on the need assessed by the team professionals, although without effective systematization.

It has been identified that DVs often go beyond follow-up, ACS are also responsible for developing activities that can facilitate the routine of the people they accompany, such as the delivery of inputs, prescriptions and medications.

Regarding the difficulties faced, the study shows that they directly interfere with the care and were related to family charges for activities that are not their responsibilities; non-acceptance of the ACS professional at the residence; the illiteracy of users, as it interferes with self-care; and difficulties within the work team, for not being able to communicate effectively, besides the rotation of the medical professional in the team, directly interfering in the quality of the assistance offered.

However, CHWs show flexibility and commitment in their role of accompanying users in their area of responsibility that are their responsibility. Allowing a link between the community and the health service built to provide improvements in the local health setting.

ATUAÇÃO DOS AGENTES COMUNITÁRIOS DE SAÚDE ÀS PESSOAS DEPENDENTES DE CUIDADOS DECORRENTES DA DOENÇA CRÔNICA

RESUMO

O objetivo deste estudo foi conhecer as ações em saúde realizadas pelos Agentes Comunitários de Saúde às famílias de pessoas dependentes de cuidados. O estudo é de natureza qualitativa, realizado com 21 profissionais que integram equipes da Estratégia Saúde da Família de um município de pequeno porte, localizado na região noroeste do estado do Paraná. Para a coleta de dados utilizou-se entrevista semi-estruturada que foram submetidas à análise de conteúdo na modalidade temática. Evidenciou-se facilidades relacionadas ao vínculo criado com as famílias assistidas, a à equidade da assistência e a à receptividade dos usuários ao trabalho dos Agentes Comunitários de Saúde. Apontou-se Foram apontadas dificuldades na assistência, como baixa escolaridade, medo causado pela presença de drogadição nas áreas de abrangência e sobrecarga de trabalho. Na questão organizacional, a ineficiência dos serviços especializados, falta de transporte para as visitas e de materiais necessários para a rotina de trabalho foram considerados como fatores que impedem a realização de uma assistência mais adequada. Conclui-se que os Agentes Comunitários de Saúde, que acompanham as famílias de pessoas dependentes de cuidado, têm seu trabalho interferido negativamente pelas dificuldades encontradas no dia a dia, as quais necessitam ser improvisadas cotidianamente para que a assistência seja prestada.

Palavras-chave: Agentes comunitários de saúde. Educação em saúde. Atenção primária à saúde. Doença crônica. Família.

ACTUACIÓN DE LOS AGENTES COMUNITARIOS DE SALUD A LAS PERSONAS DEPENDIENTES DE CUIDADOS RESULTANTES DE LA ENFERMEDAD CRÓNICA

RESUMEN

El objetivo de este estudio fue conocer las acciones en salud realizadas por los Agentes Comunitarios de Salud a las familias de personas dependientes de cuidados. El estudio es de naturaleza cualitativa, realizado con 21 profesionales que forman parte de equipos de la Estrategia Salud de la Familia de un municipio de pequeño porte, ubicado en la región noroeste del estado de Paraná. Para la recolección de datos se utilizó entrevista semiestructurada que fue sometida al análisis de contenido en la modalidad temática. Se evidenciaron facilidades relacionadas al vínculo creado con las familias asistidas, a la equidad de la asistencia y a la receptividad de los usuarios al trabajo de los Agentes Comunitarios de Salud. Fueron señaladas dificultades en la asistencia, como baja escolaridad, miedo causado por la presencia de drogodependencia en las áreas de funcionamiento y sobrecarga de trabajo. En la cuestión organizacional, la ineficiencia de los servicios especializados, falta de transporte para las visitas y de materiales necesarios para la rutina de trabajo fueron considerados como factores que dificultan la realización de una asistencia más adecuada. Se concluye que los Agentes Comunitarios de Salud, que acompañan a las familias de personas dependientes de cuidado, tienen su trabajo interferido negativamente por las dificultades encontradas en el día a día, que necesitan ser improvisadas cotidianamente para que la asistencia sea prestada.

Palabras clave: Agentes comunitarios de salud. Educación en salud. Atención primaria de salud. Enfermedad crónica. Familia.

REFERENCES

1. World Health Organization. Global action plan for the prevention and control of noncommunicable diseases: 2013-2020. 2013. [Citado 2017 set30] Available from: http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf.

2. Kontis V, Mathers CD, Rehm J, Stevens GA, Shield KD, Bonita R, et al. Contribution of six risk factors to achieving the 25×25 non-communicable disease mortality reduction target: a modelling study. The Lancet. 2014 Aug; 384(9941):427–37. doi: https://doi.org/10.1016/S0140-6736(14)60616-4.

3. Ministério da Saúde (BR). Vigitel Brasil 2015 Saúde Suplementar: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico / Ministério da Saúde, Agência Nacional de Saúde Suplementar. Brasília, DF: Ministério da Saúde, 2017. Disponível em: https://www.ans.gov.br/images/stories/Materiais_para_pesquisa/Materiais_por_assunto/2015_vigitel.pdf.

4. Malta DC, Silva Jr JB. O Plano de Ações Estratégicas para o Enfrentamento das Doenças Crônicas Não Transmissíveis no Brasil e a definição das metas globais para o enfrentamento dessas doenças até 2025: uma revisão. Epidemiologia e Serviços de Saúde. 2013 Mar; 22(1):151–64. doi: http://dx.doi.org/10.5123/S1679-49742013000100016.

5.Salci MA, Meirelles BHS, Silva DMGV. Primary care for diabetes mellitus patients from the perspective of the care model for chronic conditions. Rev. Latino-Am Enfermagem, 2017[citado 2017 set30];25: e2882. doi: http://dx.doi.org/10.1590/1518-8345.1474.2882.

6. Ministério da Saúde (BR). Portaria nº 2.436, de 21 de setembro de 2017. Política Nacional de Atenção Básica. Brasília, DF: Ministério da Saúde; 2017. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html.

7. Ministério da Saúde (BR), Departamento de Atenção Básica [Internet]. Brasília: Ministério da Saúde; 2012. Teto, credenciamento e implantação das estratégias de agentes comunitários de saúde, saúde da família e saúde bucal. Unidade Geográfica: Brasil. Competência: setembro de 2017 [citado 2017 set 17]. Disponível em: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php.

8. Machado LM, Mattos KM, Colomé JS, Freitas NQ, Sangoi TP. Family health strategy: the perception of community health agents concerning their work. Cienc. Cuid. Saúde. 2015 [citado2017 set28];14(2):1105-12. doi: http://dx.doi.org/10.4025/cienccuidsaude.v14i2.22612.

9. Andrade VMP, Cardoso CL. Visitas Domiciliares de Agentes Comunitários de Saúde: Concepções de Profissionais e Usuários. Psico-USF. 2017 Apr;22(1):87–98. doi: http://dx.doi.org/10.1590/1413-82712017220108.

10. Silveira MPR, Silva MRS, Farias FLR, Moniz ASB, Ventura J. Autonomy and social reintegration: perception of families and professionals who work with harm reduction. Ciência, Cuidado e Saúde. 2017 Oct. 27;16(3). doi: http://dx.doi.org/10.4025/cienccuidsaude.v16i3.34299.

11. Instituto Paranaense de Desenvolvimento Econômico e Social (PR). Caderno estatístico: Município de Marialva [Internet]. Curitiba; 2017 [citado 2017 mar. 26]. Disponível em: http://www.ipardes.gov.br/cadernos/MontaCadPdf1.php?Municipio=86990&btOk=ok.

12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 13ª Ed. Rio de Janeiro: Abrasco; 2013.

13. Cunha MS, Sá MC. A visita domiciliar na estratégia de saúde da família: os desafios de se mover no território. Interface Comum. Saúde Educ. 2013[citado 2017 set 28];17:61-73. doi: http://dx.doi.org/10.1590/S1414-32832013000100006.

14. Kebian VA, Oliveira AS. Health practices of nurses and community health agents of the family health strategy. Ciênc. Cuid Saúde. 2015[citado 2017 set 25]; 14(1):893-900. doi: http://dx.doi.org/10.4025/cienccuidsaude.v14i1.22466.

15.Freitas PS, Matta SR, Mendes LVP, Luiza VL, Campos MR. Use of health services and medicines by hypertensive and diabetic patients in the municipality of Rio de Janeiro, Brazil.CiênSaúdeColetiva.2018 [citado 2018out 27];23(7):2383-2392. doi: http://dx.doi.org/10.1590/1413-81232018237.21602016.

16. Maia ER, Pagliuca LMF, Almeida PC de. Learning of community health agent to identify and register disabled people. Acta Paulista de Enfermagem. 2014 Aug;27(4):326–32. doi: http://dx.doi.org/10.1590/1982-0194201400055.

17. Pinto AGA, Jorge MSB, Marinho MNASB, Vidal ECF, Aquino PS, Vidal ECF. Experiences in the Family Health Strategy: Demands and vulnerabilities in the territory. Rev. Bras. Infirm. [Internet]. 2017 [citado 2017 set 28], 70(5):920-7. [Thematic Edition "Good practices and fundamentals of Nursing work in the construction of a democratic society"]. doi: https://dx.doi.org/10.1590/0034-7167-2015-0033.

18. Lanzoni GMM, Cechine C, Meirelles BHS. Agente Comunitário de Saúde: estratégias e consequências da sua rede de relações e interações. Rev. Rene. 2014 [citado 2017 out 12]; 15(1):123-31. doi: http://dx.doi.org/10.15253/rev%20rene.v15i1.3096.

19. Santos BMO, Caixeta ACM, Silva AA, Teixeira CRS. Conhecimento e atitudes em diabetes mellitus tipo 2: subsídios para autocuidado e promoção de saúde. Arq. Ciênc. Saúde [internet]. 2016[citado 2017 set 28];23(4):31-6. Disponível em: http://www.cienciasdasaude.famerp.br/index.php/racs/article/view/443/246.

20. Briese G, Lunardi VL, Azambuja EP, Kerber NPC. Moral distress of health community agents. Ciênc. Cuid Saúde. 2015[citado em 2017 out. 10]; 14(2):1035-42. doi: http://dx.doi.org/10.4025/cienccuidsaude.v14i2.17696.

Corresponding author: Anderson da Silva Rêgo. Departamento de Pós-Graduação em Enfermagem, Universidade Estadual de Maringá - UEM. Av. Colombo, 5790 - Cidade Universitária, CEP 87020-900 - Maringá, PR, Brasil. Telefone: (44) 3011-4318. E-mail: anderson.dsre@hotmail.com / andersondsre@gmail.com

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