http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI 10.4025/ciencuidsaude.v21i0.62412

ORIGINAL ARTICLE

IMPLEMENTATION OF THE ATTRIBUTE COMMUNITY ORIENTATION IN THE PERSPECTIVE OF THE ELDERLY AND HEALTH PROFESSIONALS

Daniela Bulcão Santi*
Guilherme Kenzo Acutu**
Poliana Avila Silva***
Iara Sescon Nogueira****
Larissa Padoin Lopes*****
Vanessa Denardi Antoniassi Baldissera******

ABSTRACT

Objective: to evaluate the implementation of the attribute Community Orientation in the care provided to the elderly in Primary Health Care from the perspective of them and health professionals. **Method:** qualitative and evaluative research, developed with eight elderly and seven professionals from a Basic Health Unit of a municipality in the state of Paraná, Brazil. Data were collected between February and March 2020 through individual interviews with a constructed script guided by the Primary Care Assessment Instrument validated in Brazil. The data were organized and analyzed through the construction of Evaluative Matrices. **Results:** the demands and practices related to the attribute Community Orientation were identified. These corresponded to collective actions, home visits, operative groups, local health council, and the link between the elderly and health professionals. **Final thoughts:** the elderly and professionals have different perspectives on the attribute Community Orientation, and these complement a dynamic process of primary health care work with potential and weaknesses.

Keywords: Primary health care. Health of the elderly. Health evaluation. Health services research. Community participation.

INTRODUCTION

The elderly population has been increasing at an accelerated pace due to several factors, which implies changes and challenges in society, especially on the organization of social assistance and health[1].

It is known that 75.3% of the Brazilian elderly depend exclusively on the services provided by the Unified Health System (UHS)[2]and, in this scenario,an incentive to rights security has been built, culminating in landmarks such as the National Health Policy of the Elderly Population and the Byelaw of the Elderly[3].

Despite this, there are pressing challenges. Data from the Brazilian Longitudinal Study of Aging (ELSI-Brazil, *Estudo Longitudinal da Saúde dos Idosos Brasileiros*) demonstrate inequalities in access and health coverage of the elderly population, reflecting a care centered on chronic conditions[4]. This study also pointed out that care for the most vulnerable elderly is often neglected. This can be observed in the ratified associations in which frail elderly people or those with worse socioeconomic conditions have more problems in PHC and higher health expenditures, respectively[5,6].

Thus, it is important to rethink the logic of care for the elderly in the context of Primary Health Care (PHC) to mitigate these problems and promote, in an integral perspective, healthy aging[4,7].

In order to ensure the quality of PHC actions, the international literature has a Primary Care Assessment Tool (PCATool) that lists the key attributes that allow evaluating the service offered to the population[7]. There are seven attributes, which are subdivided into *essential attributes*: first contact access, longitudinality,

*Nurse. Doctor in Nursing. Instituto Federal Catarinense. Blumenau-SC, Brazil. E-mail: danielabsanti@gmail.com. ORCID iD: https://orcid.org/0000-0001-8687-9877.
**Nursing Student. Universidade Estadual de Maringá. Maringá-PR, Brazil. E-mail: guilherme_kenzo_@hotmail.com. ORCID iD: https://orcid.org/0000-0002-5940-8110.
***Nurse. Master in Nursing. Universidade Estadual de Mato Grosso do Sul. Dourados-MS, Brazil. E-mail: polianauem@gmail.com. ORCID iD: https://orcid.org/0000-0002-5930-7424.
****Nurse. Doctor in Nursing. Universidade Estadual de Maringá. Maringá-PR, Brazil. E-mail: iara_nogueira@hotmail.com. ORCID iD: https://orcid.org/0000-0001-5815-9493.
*****Nurse. Resident in Nursing Services Management. Universidade Estadual de Londrina. Londrina-PR, Brazil E-mail: laripadoinlopes@gmail.com. ORCID iD: https://orcid.org/0000-0002-4281-9829.
******Nurse. Doctor in Nursing. Universidade Estadual de Maringá-PR, Brazil. E-mail: vdabaldissera2@uem.br. ORCID iD: https://orcid.org/0000-0003-1680-9165.

comprehensiveness and coordination of care; and in derived attributes: family orientation; community orientation and cultural competence[7,8].

In relation to the derived attributes, the Community Orientation stands out, which seeks to identify health needs and carry out the planning and joint evaluation of services, using clinical skills, social sciences and evaluative research, in a complementary way, through direct contact with the population[6].The community orientation consists of six indicators, which seek to show how home visits occur, knowledge of community health problems, the ways of listening to community opinions and ideas on how to improve health services and participation in the Local Health Council (LHC)[7,8].

Community orientation is essential for the care of the elderly in PHC, as it provides their inclusion in society, ensuring their central role and autonomy. There is a lack of current studies on the evaluation of this attribute with older adults, and these studies reveal low scores[9-12], indicating dissatisfaction or unmet expectations about community orientation. In this sense, knowing also the perceptions of health professionals, active actors in this process, is relevant in order to face and complement the perceptions about this scenario.

Thus, it becomes relevant to propose a qualitative research, in which the perspectives of the elderly and health professionals can be better evidenced, allowing analyzing the potentialities and challenges related to this attribute. From this scenario, this study aimed to evaluate the implementation of the attribute Community Orientation in the care provided to the elderly in Primary Health Care from the perspective of the elderly themselves and health professionals.

METHOD

This was a qualitative research, of the evaluative type, developed in a Basic Health Unit (BHU) located in a city of the Northern Central Region of the state of Paraná, Brazil.

The target audience of the study were nine BHU professionals and 14 elderly residents of the coverage area. The participants were selected for convenience, through the previous contact of the researchers with the study site in an extension project in Nursing, the ADEFI (Nursing Home Care to Families of the Elderly dependent on care - *Assistência Domiciliar de Enfermagem às Famílias de Idosos dependentes de cuidado*)developed in this unit since 2016.

Regarding the elderly, the inclusion criteria for participation in the research were being aged equal to or greater than 60 years; being registered in the BHU for more than two years; and having participated in nursing consultations to the elderly. These criteria were defined in order to allow participants to be effective users of PHC. As exclusion criteria, it was chosen not to be located in their address after two contact attempts; and not to present preserved cognitive capacity according to the Mini Mental State Examination (MMSE)[13].

For health professionals, the inclusion criteria were to be a health professional working in the BHU surveyed; and to work in PHC for more than six months. Those who were temporarily absent from their duties for reasons of leave or vacation were excluded.

Through face-to-face contact with BHU professionals and home visits to the elderly, all participants were invited to join the study. It is noteworthy that three elderly people were not located in their addresses and three had low scores in the MMSE, being excluded. Concerning health professionals, there was one refusal to participate in the research and one was absent.

Thus, seven health professionals and eight elderly people participated in the research. This quantitative considered the empirical evidence of theoretical data saturation[14], and the content of the interviews was sufficient to contemplate the objective of the study.

Data collection took place from February to March 2020. Two semi-structured scripts were elaborated by the researchers themselves, one for professionals and another for the elderly, both composed of questions of sociodemographic characterization and referring to the attribute of Community Orientation, based on the validated and updated instrument in Brazil, PCATool[8]. These scripts with adequacy instrument[15]were sent by e-mail and evaluated by three judges with expertise in the theme, title of doctors and area of expertise in gentontology and PHC in

order to provide the refinement of the issues that addressed PCATooL.

To characterize the elderly, gender, age, marital status, schooling, social status of housing, monthly family income and source of income were investigated. Professionals, in addition to these variables, questioned the professional category, the time of work in the PHC and the BHU researched, the workload, and resides in the area covered by the BHU researched.

The questions directed to the elderly covered the following guiding questions: which health professional in the unit knows you best as a person? What is his/her name? Which health professional in the unit is most responsible for your health care? What is his/her name? Do you think the unit investigates what are the health problems of the community's elderly? How does it do that? In your opinion, what is the main health problem of the elderly in this community? Cite community actions that the unit develops for the elderly in the community. Tell the positive and negative points about the groups/actions that are developed by the unit. Tell positive and negative points about the home visits that are developed by the unit. In your opinion, is the service provided by the unit efficient? What could be done to improve it? What do you know/experience about the Local Health Council? Have you been invited and/or participated? What is its importance for the health of the community?

For the professionals, these were guiding questions: talk about how the team is organized to identify and meet the health problems of the elderly in the community. In your opinion, what is the main health problem of the elderly in this community? Are there actions aimed at this problem? Do you think the team is able to perform community guidance? What are the difficulties? Tell the positive and negative points about the groups/actions that are developed by the unit. Tell positive and negative points about the home visits that are developed by the unit. What do you know/experience about the Local Health Council? Have you participated? Have you guided users about social participation in the Council? What is its importance for community health? Is there community participation in the unit's work process? How does the unit favor this?

The interviews had an average duration of 10 minutes, were recorded using a mobile phone application and conducted by six trained researchers, who are part of the ADEFI Project. Afterwards, they were fully transcribed and submitted to evaluative analysis, through the construction of Evaluative Matrices[16], guided by the attribute of Community Orientation[7,8]. This method was chosen because of the potential to integrate the sources of information and to favor the analysis of the problems and challenges of the investigated problem, thus the stages of systematization of the information, analysis of the main theoretical elements and elaboration and organization of the dimensions of analysis in a matrix were followed[16,17].

In order to subsidize the construction of the evaluative matrices, some excerpts of speeches of the participants are presented. These were coded by letters E (elderly) and P (professional), followed by the Arabic number corresponding to the interview order.

It should be noted that the study included all the criteria established in the Consolidated criteria for Reporting Qualitative research (COREQ), a tool used to support the methods of qualitative studies[18]. The research followed the current ethical precepts, expressed in Resolutions 466/2012 and 510/2016 of the National Health Council, and was approved by the Human Research Ethics Committee, under protocol N. 1.954.350/2017 (CAAE: 37457414.6.0000.0104).

RESULTS

The participants were seven health professionals and eight elderly people. As for health professionals, six were female and the average age was 44 years. Regarding schooling, four had completed higher education and three had completed high school. Regarding the professional category, two were Community Health Workers (CHW), a nursing assistant, a nurse, a dentist, a physical educator and a doctor. Four worked in PHC for more than five years. All had a workload of 40 hours per week and only two reported having another source of income. In addition, only two health professionals lived in the area covered by the unit studied.

As for the eight elderly participants, six were female, five sexagenarian, and seven lived with other people. Concerning marital status, three were married, two single, two widowed and one divorced. Four elders reported having education between 5 and 10 years of schooling and family income between 1 and 2 minimum wages, with retirement being the main source of income.

Two evaluative matrices were constructed from the perspectives of the elderly and health professionals. These matrices were composed of two theories that encompass, respectively, the identification of demands and practices of community orientation, entitled "Community Orientation and its challenges are recognized in the actions of the service" (Figure 1) and "Social participation is fundamental to the implementation of the Community Guideline" (Figure 2), as follows:

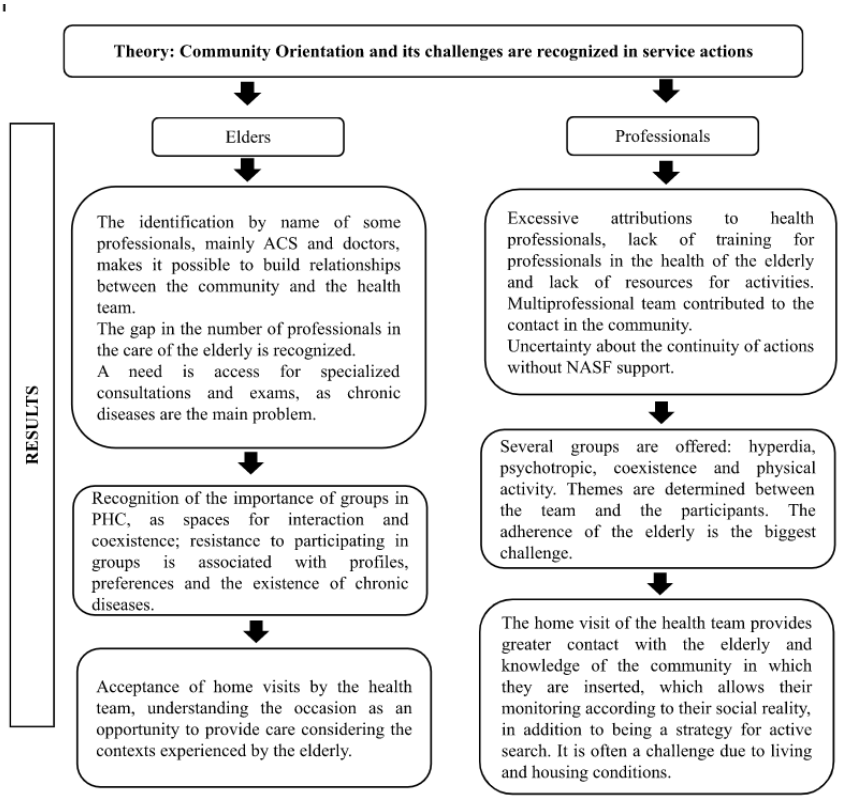

Figure 1. Evaluative matrix of the attribute Community Guidance in PHC directed to the health of the elderly from the perspective of health professionals and elderly people, according to the identification of demands and practices carried out.

Some statements confirm the information of the elderly synthesized in the Matrix, presented below:

> "When my mother was sick, I received the doctor, he and the nurses. It was a good, very good experience. Until the day the doctor said to me that we had to take her to the hospital because she was not well and called an ambulance to take her. So it was... so there was that girl who comes by, the assistant (CHW). Wow, a lovely person. She would come, and when my niece next door was pregnant... she would came several times, asked if she needed anything. Wow, this post is really good!" **E2**

> "I went to the doctor, I don't even know his name, he saw me, made me... wow, so many exams! When I returned, he turned to me and asked and said "who are you?". I said I was nobody and that I had never came here." **E3**

> "I call it directly (Health Department). She says: No, you have a light level, it will take a while, you are still in the queue, it will take a long time,

and my knee has worsened a lot in a year, I have tingling in both legs and the ultrasound's resultis not ready yet, but when we have to undergo an exam at the health center [...] the service is awesome, I love it and I'm very well assisted." **E8**

"I sit and cry to this day for not being able to participate (in the group) anymore, because we used to stay there for an hour or so, but it's the best thing this BHU has ever done here in this neighborhood, it's an extra learning experience in the life, we talk, get distracted, visit various places"**E1**

"There are things I don't like, when it's to sing I don't like (laughs), I never go out for a walk either because I don't have money so I'm ashamed and I don't go, and I think that's all." E5

As regards health professionals, the representative contributions are presented below:

"The elderly are sometimes resistant, they don't want care. Sometimes we also make an appointment, they are sick and don't come... but then, as they are priorities, we understand and try to fit in." **P2**

"We have the schedule (of the groups) there and we write it down, we wrote down last year to compare what we did, what we could do, we asked them for their opinion". **P3**

"We are aware of the importance of the group for the elderly. Group participants feel like family. The group is the place where leisure, mental health, coexistence, health education, among others are offered."**P4**

"They don't join (actions and groups), you keep asking why they don't join, you are always in the neighborhood, close to the BHU, they don't pay anything and don't come. [...] there are never enough materials, so we have to take them out of our pockets, you know, whatever it is, sometimes there is E.V.A. to do some crafts. Just like in pink October, everyone arrives here beautiful and wonderful, right, coffee, feast, decorate with balloons, decorate with non-wovens, we organize, each one contributes financially, and someone goes there and buys, this happens in all actions."**P5**

"We don't get good patient compliance, treatment abandonment, examinations not being performed and guidance not being followed, I spend the whole day here telling people to move and they don't."**P7**

"(in the home visit) you will work in an environment that is not exactly an outpatient environment, where you often see the house in a deplorable condition, [...] you will see unassisted people, abandoned, with no care, no family member, someone who can answer for their treatment."**P7**

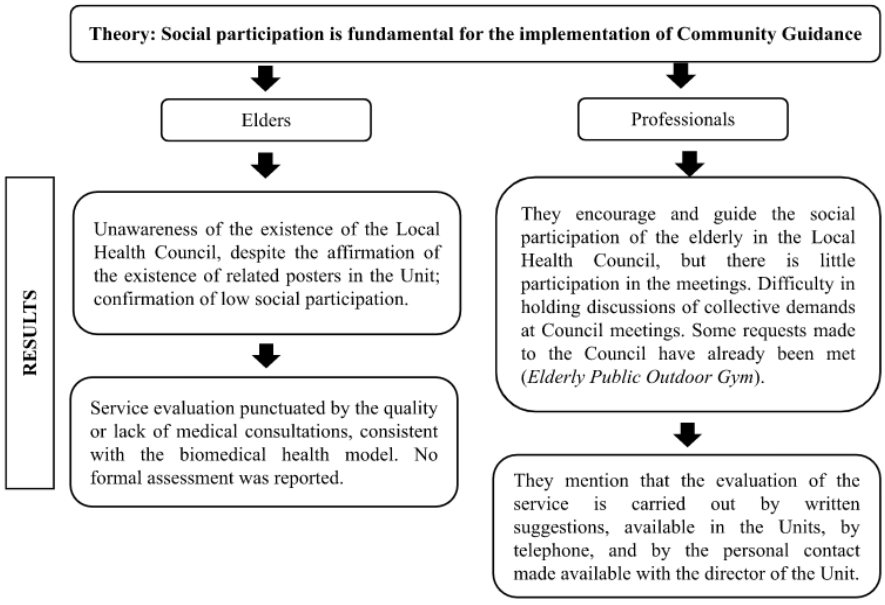

Figure 2. Evaluative matrix of the attribute Community Guidance in PHC directed to the health of the elderly from the perspective of health professionals and elders, according to the importance of participation.

This Matrix (Figure 2) comprises social participation mainly related to the operationalization of the LHC and the availability of the BHU for access by the elderly in the processes of evaluation and construction of actions. The speeches that added to this construction are presented below:

> "I went only once (LHC), but nobody goes. I say that only my awareness will not solve the problem, and as much as I tell people, invite and talk about the importance, they seem not to be interested in them, in us, in the country, in the people, anyway…"**E6**

> "They're always the same. We see it like this, people don't show interest in contributing to the functioning of the health unit, in fact when someone different goes, it's to put something personal, so I think this is very sad." **P1**

> "They have the opportunity to come to the council to do so, but participation is practically nil. There is a suggestion box also in the unit and I believe the unit direction is available for suggestions." **P4**

> "Several things that we see the need of the population are discussed in these meetings. The EPOG (Elderly Public Outdoor Gym), when we went to do it there in the square, it was a discussion that we brought up several times there, then we took the project there to the mayor." **P6**

DISCUSSION

This research enabled participants, elders and health professionals, to discuss their experiences related to Community Orientation, thus favoring the evaluation of this attribute of PHC.

In the evaluative matrix, under the Theory "Community Orientation and its challenges are recognized in the actions of the service", it is understood that the elderly have a positive perception of this attribute, since they claim to have a link with health professionals and recognize services offered in the unit. This bond is important for a humanized care, because it enables the elderly to adhere to the actions developed, creating trust relationships to explain their complaints[7,19].

From the perspective of health professionals, despite facing difficulties inherent to professional performance in the PHC of the country, this study recognizes strategies that configure the implementation of Community Guidance, as is the case of the multiprofessional team, of home visits, operating groups and collective actions.

The home visit was indicated as one of the potential of the service, understood as a light technological resource, and permeates subjective and objective interventions of nursing care to the elderly in PHC, promoting the formation of bonds and the transformation of health and life habits[20]. On the other hand, home visits are also a challenge, as they require care outside the appropriate environment of the unit, and it is on this occasion that professionals face the elderly in palliative care conditions or abandonment and neglect; findings that may generate distress in professionals[21].

In the research unit, the home visit takes place during a period of the week, with the growing demand of the elderly and the complexity involved, the increase in the supply of home visits should be predicted in Primary Care. In this context, it is necessary to value the work of the CHW, since this category was recognized by the elderly as the main reference in community health care. Therefore, instead of prioritizing a monthly quota of home visits, it is important to consider the elderly population in the territory, since the visit to them is differentiated, requiring more time and attention[19].

As for the operating groups of the unit, which include socialization activities, related to leisure and health promotion, the elderly refer to them as spaces for interaction and coexistence; on the other hand, some elders showed disinterest due to the type of activities developed or mobility restrictions. It is important that these health actions are problematized and prioritized in the context of local health planning, considering the real needs and expectations of the elderly[22,23].

In the second theory of the evaluative matrix, "Social participation is fundamental for the implementation of Community Orientation", most elders are unaware of the functioning and attributions of the LHC. Despite linking posters in the unit to this proposal, the social participation of the elderly is still a challenge. Thus, it is necessary to invite and inform the elderly about the relevance and dynamics of the operative groups and meetings of the LHC, because they can feel safer and motivated to

participate, also affecting their autonomy and independence, since those spaces favor interaction and social mobilization[23].

In relation to this theory under the eyes of health professionals, the LHC appears as a driving experience of advances and its difficulties relate to little social participation for agreement and resolution of collective demands. Thus, it is necessary to promote the dissemination of councils in several channels for greater dissemination and adherence of society[24]. It is also important to consider the accessibility of this information to the elderly population.

Finally, the elderly reported not participating in formal evaluation processes of the health service. Some of them referred the quality of the unit's care to medical care, which reflects the biomedical culture and, moreover, represents the professional centrality as a challenge for the longitudinality of care[7,25].

It is recommended that the service establish the centrality in the user favoring accessibility and evaluation of the established processes[7]. For evaluation of the services, some actions were cited by professionals, such as suggestion box, customer service telephone and contact with the direction/coordination of the unit.

In this compiled evaluation of Community Orientation conducted in this research, it is understood that it is essential to consider the knowledge and experience of professionals and the community, especially the elderly. For a better organization of the actions developed, in order to be improved, these must be evaluated by all involved constantly.

As for the limitations of the study, it is pointed out the election of elderly participants, because they are participants of a BHU follow-up group, in which there is bond and belonging, thus the findings may not translate the perceptions of other elders in the area of coverage.

FINAL CONSIDERATIONS

The attribute of community orientation in PHC was evaluated from the perspective of the elderly and health professionals. It was observed that community orientation is a dynamic process in the development of the work of PHC and provides the elderly access to health in the context analyzed with potential and weaknesses.

Community orientation strategies, such as home visits, groups, collective actions and LHC, are developed, however should be planned and built in a participatory way, considering the preferences of the elderly, to meet their real needs and social participation, since the involvement of this population will bring greater benefits to health, in addition to allowing direct contact to debate and expose their opinions and suggestions.

The contributions of this study to the area of Nursing concern the knowledge of relevant factors for effective community orientation. Being the nurse essential for the mobilization of both the team and the community, it is important that this professional's practice, teaching and research has current and diverse evaluation foundations that represent the quality of PHC.

It is suggested the adoption of strategies that stimulate the empowerment of professionals and the elderly from the perspective of Community Orientation, since this attribute represents a fundamental foundation of PHC.

IMPLEMENTAÇÃO DO ATRIBUTO ORIENTAÇÃO COMUNITÁRIA NA PERSPECTIVA DE IDOSOS E PROFISSIONAIS DE SAÚDE

RESUMO

Objetivo: avaliar a implementação do atributo Orientação Comunitária no atendimento prestado aos idosos na Atenção Primária à Saúde na perspectiva dos mesmos e de profissionais de saúde. **Método:** pesquisa qualitativa e avaliativa, desenvolvida com oito idosos e sete profissionais de uma Unidade Básica de Saúde de um município no estado do Paraná, Brasil. Os dados foram coletados entre fevereiro e março de 2020 por meio de entrevistas individuais com roteiro construído e orientado pelo Instrumento de Avaliação da Atenção Primária validado no Brasil. Os dados foram organizados e analisados através da construção de Matrizes Avaliativas. **Resultados:** identificaram-se as demandas e práticas relacionadas ao atributo Orientação Comunitária. Essas corresponderam a ações coletivas, visitas domiciliares, grupos operativos, conselho local de saúde, além do vínculo entre idosos e profissionais de saúde. **Considerações finais:** avaliou-se que idosos e profissionais têm diferentes perspectivas sobre o atributo Orientação Comunitária, sendo que essas complementam um processo dinâmico do trabalho da atenção primária à saúde com potencialidades e fragilidades.

Palavras-chave: Atenção Primária à Saúde. Saúde do Idoso. Avaliação em Saúde. Pesquisa sobre Serviços de Saúde. Participação da Comunidade.

IMPLEMENTACIÓN DEL ATRIBUTO ORIENTACIÓN COMUNITARIA DESDE LA PERSPECTIVA DE LAS PERSONAS MAYORES Y DE LOS PROFESIONALES DE LA SALUD

RESUMEN

Objetivo: evaluar la implementación del atributo Orientación Comunitaria en la atención prestada a los ancianos en la Atención Primaria de Salud desde su perspectiva y de los profesionales de salud. **Método**: investigación cualitativa y evaluativa, desarrollada con ocho ancianos y siete profesionales de una Unidad Básica de Salud de un municipio en el estado de Paraná-Brasil. Los datos fueron recolectados entre febrero y marzo de 2020 por medio de entrevistas individuales con guion construido y orientado por el Instrumento de Evaluación de la Atención Primaria validado en Brasil. Los datos fueron organizados y analizados a través de la construcción de Matrices Evaluativas. **Resultados**: se identificaron las demandas y prácticas relacionadas al atributo Orientación Comunitaria. Estas respondieron a acciones colectivas, visitas domiciliarias, grupos operativos, consejo local de salud, además del vínculo entre personas mayores y profesionales de salud. **Consideraciones finales**: se evaluó que los ancianos y profesionales tienen diferentes perspectivas sobre el atributo Orientación Comunitaria, siendo que estas complementan un proceso dinámico del trabajo de la atención primaria de salud con potencialidades y fragilidades.

Palabras clave: Atención Primaria de Salud. Salud del Anciano. Evaluación en Salud. Investigación sobre Servicios de Salud. Participación de la Comunidad.

REFERENCES

1. Fulmer T, Patel P, Levy N, Mate K, Berman A, Pelton L, et al. Moving toward a global age-friendly ecosystem. J Am Geriatr Soc.2020;68(9):1936-1940. DOI: 10.1111/jgs.16675.

2. Fundação Oswaldo Cruz. Estudo aponta que 75% dos idosos usam apenas o SUS. [Internet]. 2018 [acesso em 21 jan 2021]. Disponível em: https://portal.fiocruz.br/noticia/estudo-aponta-que-75-dos-idosos-usam-apenas-o-sus.

3. Torres KRRO, Campos MR, Luiza VL, Caldas CP. Evolução das políticas para a saúde do idoso no contexto do Sistema Único de Saúde. Physis. 2020;30(1):1-22. DOI: 10.1590/S0103-73312020300113

4. Macinko J, Bof de Andrade F, Souza-Junior PRB, Lima-Costa MF. Primary care and healthcare utilization among older Brazilians (ELSI-Brazil). Rev Saude Publica. 2018;52 Suppl 2:6s.DOI: 10.11606/S 1518-8787.2018052000595.

5. Bernardes GM, Saulo H, Fernandez RN, Lima-Costa MF, Bof de Andrade. Gasto catastrófico em saúde e multimorbidade entre idosos no Brasil. Rev Saude Publica. 2020;54:125. DOI: 10.11606/s1518-8787.2020054002285.

6. Silva AMM, Mambrini JVM, Andrade JM, Bof de Andrade F, Lima-Costa MF. Fragilidade em idosos e percepção de problemas em indicadores de atributos da atenção básica: resultados do ELSI-Brasil. Cad Saude Publica. 2021;37(9):e00255420. DOI: 10.1590/0102-311X00255420.

7. Starfield B. Atenção primária:equilíbrio entre a necessidade de saúde, serviços e tecnologias.Brasília: Ministério da Saúde, 2002.

8. Brasil. Ministério da Saúde. Manual do instrumento de avaliação da atenção primária à saúde: Primary Care Assessment Tool (PCATool – Brasil). Brasília: Ministério da Saúde; 2020.

9. Augusto DK, Lima-Costa MF, Macinko J, Peixoto SV. Fatores associados à avaliação da qualidade da atenção primária à saúde por idosos residentes na Região Metropolitana de Belo Horizonte, Minas Gerais, 2010.Epidemiol. Serv. Saúde. 2019;28(1):1-12. DOI: 10.5123/S1679-49742019000100017.

10. Araújo LUA, Gama ZAS, Nascimento FLA, Oliveira HFV, Azevedo AM, Almeida Júnior HJB. Avaliação da qualidade da atenção primária à saúde sob a perspectiva do idoso. Ciênc. Saúde Colet. 2014;19(08):3521-3532. DOI: 10.1590/1413-81232014198.21862013.

11. Macedo VLM, Vieira LF, Neves RS, Leandro SS. Avaliação da estratégia saúde da família em São Sebastião – DF. Enferm. Foco. 2019 [acesso em 06 jun 2021]; 10(2):15-21. DOI: 10.21675/2357-707X.2019.v10.n3.2330.

12. Shimizu HU, Ramos MC. Avaliação da qualidade da estratégia saúde da família no Distrito Federal. Rev. Bras. Enferm. 2019;72(2):385-392. DOI: 10.1590/0034-7167-2018-0130.

13. Brasil. Ministério da Saúde. Departamento de Atenção Básica. Envelhecimento da pessoa idosa. Caderno da atenção básica, n. 19 Brasília: Ministério da Saúde; 2006.

14. Hennink M, Kaiser BN. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. Soc. Sci. Med. 2022; 292:114523. DOI: 10.1016/j.socscimed.2021.114523

15. Manzini EJ. Considerações sobre a elaboração de roteiros para entrevista semi-estruturada. In: Marquezine MC, Ameida MA, Omote S. et al(Org). Colóquios sobre pesquisa em educação especial. Londrina: Eduel, 2003, p.11-25.

16. Magalhães R. Implementação de programas multiestratégicos: uma proposta de matriz avaliativa. Ciênc. Saúde Colet. 2014;19(1):2115-2123. DOI: 10.1590/1413-81232014197.08482013.

17. Lopes MTSR, Labegalini CMG, Silva MEK, Baldissera VDA. Educação permanente e humanização na transformação das práticas na atenção básica. Reme: Rev. Min Enferm. 2019;23:e-1161. DOI: 10.5935/1415-2762.20190009.

18. Souza VR, Marziale MH, Silva GT, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. Acta Paul. Enferm. 2021;34:eAPE02631. DOI: 10.37689/acta-ape/2021AO02631

19. Assis AS, Castro-Silva SR. Agente comunitário de saúde e o idoso: visita domiciliar e práticas de cuidado. Physis. 2018;28(n.spe):1-17. DOI: 10.1590/S0103-73312018280308.

20. Cabral R, Dellaroza MRG, Carvalho BG, Zani AV. O cuidado da pessoa idosa na atenção primária à saúde sob a ótica dos profissionais de saúde. Ciênc., Cuid. Saúde. 2019;18(2). DOI: 10.4025/ciencuidsaude.v18i2.45026.

21. Marques FP, Bulgarelli AF. Os sentidos da atenção domiciliar no cuidado ao idoso na finitude: a perspectiva humana

do profissional do SUS. Ciênc. Saúde Colet. 2022;25(6):2063-2072. DOI: https://doi.org/10.1590/1413-81232020256.21782018

22. Nogueira IS, Labegalini CMG, Carreira L, Baldissera VDA. Planejamento local de saúde: atenção ao idoso versus Educação Permanente em Saúde. Acta Paul Enferm. 2018;31(5):550-557. DOI: 10.1590/1982-0194201800076.

23. GAS Scolari, Derhun FM, Rissardo LK, Baldissera VDA, Radovanovic CAT, Carreira, L. Participation in the coexistence center for elderly: repercussions and challenges. Rev. Bras. Enferm. 2020;73(Suppl 3):e20190226. DOI: 10.1590/0034-7167-2019-0226.

24. Santos CL, Santos PM, Pessali HF, Rover AJ. Health Concils and dissemination of SUS management instruments: na analysis of portals in Brazilian capitals. Ciênc. Saúde Colet. 25(11), 2020. DOI: 10.1590/1413-812320202511.00042019.

Corresponding author: Daniela Bulcão Santi. Rua das Missões, 100. Blumenau, Santa Catarina, Brasil. CEP: 89051-000, E-mail: danielabsanti@gmail.com

Submitted: 28/02/2022
Accepted: 01/11/2022

Financial support:
Programa Institucional de Bolsas de Iniciação Científica PIBIC/CNPq.