

ELDERLY RECEIVING OUTPATIENT CARE: REASONS FOR ADHERENCE/ NONADHERENCE TO MEDICATION

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ABSTRACT: This study aimed to characterize the elderly receiving outpatient care in Rio Grande, Rio Grande do Sul state, Brazil, concerning their demographic and socioeconomic characteristics, health condition, medication usage and adherence to medication; to identify their self-reported reasons for adherence/nonadherence to the prescribed medication. A descriptive, cross-sectional study, with a quantitative approach, performed in the outpatient unit of a university hospital in Rio Grande do Sul, Brazil. One hundred seven elderly were interviewed in November of 2013. Data were collected with three instruments. The statistical analysis was descriptive. Among the elderly, 86.9% were adherent to medication. Wanting to feel good was the reason most often reported for adherence to the prescribed medication, and the occurrence of adverse reactions was the most often cited reason for nonadherence. The results of this study can support the development of actions that promote adherence to medication by the elderly.

DESCRIPTORS: Aged. Drug utilization. Medication adherence. Ambulatory care. Nursing.

PESSOAS IDOSAS EM ATENDIMENTO AMBULATORIAL: MOTIVOS QUE LEVAM A ADESÃO/NÃO ADESÃO AOS MEDICAMENTOS

RESUMO: Objetivou-se: caracterizar as pessoas idosas em atendimento ambulatorial quanto às variáveis demográficas, condições socioeconômicas, de saúde, uso de medicamentos e adesão à medicação; identificar os motivos referidos pelas pessoas idosas que as levam a aderir ou não à terapêutica medicamentosa prescrita. Estudo descritivo, transversal, com abordagem quantitativa, realizado no setor de atendimento ambulatorial de um hospital universitário no Rio Grande do Sul, Brasil. Foram entrevistados 107 pessoas idosas em novembro de 2013. Aplicaram-se três instrumentos na coleta de dados. Utilizou-se a estatística descritiva para análise. Entre as pessoas idosas, 86,9% eram aderentes à terapêutica medicamentosa. Querer sentir-se bem foi o motivo mais citado para aderir à terapêutica medicamentosa prescrita, e a ocorrência de reação adversa, o mais citado para não aderir. Os resultados deste estudo podem servir de subsídio para o desenvolvimento de ações que promovam a adesão à terapêutica medicamentosa pela pessoa idosa.

DESCRIPTORIOS: Idoso. Uso de medicamentos. Adesão à medicação. Assistência ambulatorial. Enfermagem.

ANCIANOS EN ATENDIMIENTO DE AMBULATORIO: MOTIVOS QUE LLEVAN A LA ADHESIÓN/NO ADHESIÓN A LOS MEDICAMENTOS

RESUMEN: Este estudio tuvo como objetivo caracterizar los ancianos en atendimento de ambulatorio cuanto a las condiciones demográficas, socioeconómicas y de salud, uso de medicamentos y adherencia a la medicación; identificar los motivos referidos por esos ancianos que llevan a la adhesión/no adhesión a la terapéutica medicamentosa. Estudio descriptivo, transversal, con abordaje cuantitativa, realizado en un servicio de ambulatorio de un hospital universitario en Rio Grande/RS, Brasil. Fueron entrevistados 107 ancianos en noviembre de 2013. Se aplicaron tres instrumentos en la recolección de datos. El análisis estadístico fue descriptivo. Entre los ancianos 86.9% eran adherentes a la terapia con medicamentos. Querer sentirse bien fue la razón más citada para adherir a la terapéutica medicamentosa prescrita y la ocurrencia de reacción adversa la más citada para no adherir. Los resultados de este estudio pueden servir de base para el desarrollo de acciones que promuevan la adherencia a la terapia con medicamentos para los ancianos.

DESCRIPTORIOS: Anciano. Utilización de medicamentos. Cumplimiento de la medicación. Atención ambulatoria. Enfermería.

INTRODUCTION

The estimated population growth indicates that the amount of elderly in the total population of Brazil is increasing every year.¹ Thus, one of the challenges for health professionals, in the third millennium, is the care of the elderly, especially for nurses, because of their direct and continuous action with these clients.

The aging of the population is progressing rapidly and represents an increase in chronic, non-communicable diseases (CNCDs), because they affect more segments of older aged individuals.² Studies indicate that 80% of the elderly living in the community have at least one CNCD.^{3,4} This type of disease requires changes in lifestyle and, in most cases, use of medications for treatment, especially among the elderly.² Brazilian studies indicate that the prevalence of use of medicines by older people is approximately 80%, and the mean consumption per day is approximately 3.5 medicinal agents.^{4,5}

Adherence to medication treatment is not performed properly by most of the elderly, and studies show a prevalence of nonadherence ranging from 12% to 72%.^{2,6} Some older people do not adhere to prescribed medication due to difficulties related to health conditions, financial issues, the complexity of the prescribed therapeutic regimen, beliefs, among other reasons.⁷ Thus, knowing the reasons leading the elderly person to take, or not take, his medications may help with the development of actions to encourage adherence. In Brazil and abroad, few studies that identify these reasons, from the perspective of older people, were found,^{7,8} justifying the need and relevance of this research.

Issues related to the health of the elderly, as well as the practices and policies of prescription, acquisition and utilization of pharmacological agents by these people, are very important in the current context of public policies, and were highlighted by the Ministry of Health as a research priority in Brazil.⁹

Knowing the profile and the reasons leading older people to follow or reject the prescribed medication therapy can promote adherence, helping health professionals / nurses to perform more appropriate care for the health needs of these

people, and can promote adherence.

Based on these data, the following research questions emerged: What are the demographic, socioeconomic, clinical, and pharmacotherapeutic characteristics of the elderly in outpatient care? What are the reasons referred to by the elders that drive their adherence/nonadherence to medication therapy?

The objectives of this study were to characterize the elderly receiving outpatient care regarding demographic and socioeconomic variables and health conditions, medications and medication adherence; to identify the reasons stated by elderly people, which lead them to follow or reject the prescribed therapy.

METHODS

This was a descriptive, cross-sectional study, with a quantitative approach; it was part of the project, "Adherence to the therapeutic and related factors in elderly receiving outpatient care." It was conducted in the outpatient care department of a university hospital in the municipality of Rio Grande do Sul, Brazil. Angiology, cardiology, pneumology, endocrinology, gastroenterology, and urology were the specialties selected for the study, because of the greater number of elderly people being monitored by those services.

The sample of the study was constituted of elderly individuals, receiving outpatient care. Inclusion criteria were: receiving outpatient care at the university hospital; taking, at least, one medicine, fifteen days before interview.

The exclusion criteria were: being treated with chemotherapy or radiotherapy, due to specific characteristics of these treatments, which can interfere with medication adherence; having undergone a surgical procedure in the fifteen days prior to data collection, due to a possible motivation of the elderly to regularly use prescription medicines to recover from the procedure; presenting rambling speech, with significant memory loss that would compromise the response to the questions of the instruments.

The sample was estimated according to the formula for infinite population: $n = (Z\alpha/2)^2 \cdot P \cdot Q /$

E^2 , where: n =sample size; P =proportion of the population of individuals belonging to the category to be studied; Q =proportion of the population of individuals who do not belong to the category of interest in this study ($Q=1-P$); $Z\alpha/2$ =critical value that corresponds to the desired confidence level; E =margin of error or maximal estimate error, which identifies the maximal difference between the sample proportion and the true population proportion.

A prevalence of 50% that maximizes the size of the sample when the prevalence is not known, a confidence level of 95%, and a 10% margin of error was used for the calculation, obtaining a sample size of $n=96$. In addition, 10% was added for confounding factors and 10% for losses, totaling $n=116$. Nine instruments were discarded after data collection due to lack of completion, with a final sample of 107 elderly. The sample was characterized as a non-probabilistic, convenience sample.

Data were collected during November of 2013, by structured interview, with three instruments. The first one characterized the elderly in terms of demographics, socioeconomics and behavioral characteristics, health conditions and medical-therapeutic factors. This instrument was validated in appearance and content, by two professors and researchers in the gerontology area, who are members of the Group for Study and Research in Gerontology, Nursing/Health and Education (GEP-GERON) of the Federal University of the city. The second instrument, the Mini Mental State Examination (MMSE) was used to assess cognition of the elderly.¹⁰ The third was the Measure of Adherence to Treatment (MAT), performed to verify the compliance of the elderly to medication therapy. This instrument was developed and validated in Portugal.¹¹

The interviews were conducted by members of GEP-GERON, who received specific training. Each elder was approached in the waiting room of the ambulatory clinic before or after medical consultation. The Terms of Free and Informed Consent was signed, or a thumb print impression of elderly who agreed to participate in the study was utilized, in duplicate copies. One copy

remained with the researcher and the other was given to the participant.

The medicines, which were part of medication therapy used by the elderly, were classified according to the Anatomical Therapeutic Chemical Code (ATCC), adopted by the World Health Organization,¹² and organized according to the anatomical group or system in which they operate and its chemical, therapeutic and pharmacological properties. The Specialty Pharmaceuticals dictionary (2010/2011) was used to identify substances from trade names.¹³ Polypharmacy was the term used when five or more medications were used concurrently for at least one week.⁴

For the organization of the data, a Microsoft Excel 2007 spreadsheet was created, containing a dictionary (codebook) and two spreadsheets used for validation using double entry (typing). The data analysis was performed using the Statistical Package for the Social Sciences® software (SPSS), version 20.0. A descriptive statistical analysis, describing the absolute and relative frequency of use, measure of central tendency (mean), and measure of dispersion (standard deviation, minimum and maximum) was performed. Prevalence ratios were calculated (PR) for the variables: sex, age, marital status, activity, education, income, polypharmacy and MMSE. The data are presented in tables.

The research project followed all ethical rules of Resolution 466/2012,¹⁴ and was approved by the Research Ethics Committee, with protocol number 164/2013.

RESULTS

Demographic and socioeconomic characteristics of the elderly

There was a predominance of elderly women (69.2%), between the ages of 60-69 (66.4%), married (59.8%), without paid activity (85.0%). The level of education was between the first and fourth grades of elementary school (42.1%), and the monthly income was one to three minimum wages (58.9%) (Table 1).

Table 1 - Distribution of elderly people receiving outpatient care, according to their demographic and socioeconomic characteristics. Rio Grande do Sul, Brazil, 2013

Variables	n	%
Sex		
Female	74	69.2
Male	33	30.8
Age group (years)		
60-69	71	66.4
70-79	28	26.1
≥ 80	8	7.5
Marital status		
Married	64	59.8
Widow(er)	26	24.3
Divorced	10	9.3
Single	7	6.5
Occupation		
No paid activity (retired or working at home)	91	85.0
Paid activity (has a job)	16	15.0
Education		
Illiterate	10	9.3
First to fourth grade	45	42.1
Fifth to eighth grade	35	32.7
Incomplete secondary education	6	5.6
Complete secondary education	8	7.5
Incomplete higher education	2	1.9
Complete higher education	1	0.9
Income		
Up to one minimum wage	29	27.1
More than one and up to three minimum wages	63	58.9
More than three minimum wages	8	7.5
Doesn't know/Didn't report	7	6.5
Total	107	100.0

*Value of the minimum wage at the time of data collection was R\$ 672.00.

Characterization of the health conditions of the elderly

The health condition of the elderly showed a median of four medical consultations per year (range of 0-20). Compared to the MMSE, 62 (57.9%) of the elderly presented normal assessment results, and 45 (42.1%), had a hypothesis of cognitive impairment.

Of the 107 respondents, 99 (92.5%) presented comorbidities, and eight (7.5%) had only one disease. According to Table 2, the most prevalent diseases were systemic hypertension (SH), present in 85 (79.4%) elderly, followed by diabetes mellitus (DM), in 61(57.0%).

Table 2 - Diseases reported by elderly receiving outpatient care. Rio Grande do Sul, Brazil, 2013

Reported disease	n	%
Hypertension	85	79.4
Diabetes mellitus	61	57.0
Heart disease	47	43.9
Arthritis	37	34.6
Dyslipidemia	30	28.0
Rheumatism	22	20.6
Thyroid problems	14	13.1
Chronic obstructive pulmonary disease	13	12.1
Depression and anxiety	11	10.3
Gastritis	8	7.5
Insomnia	7	6.5
Osteoporosis	6	5.6
Lower limb varicose veins	3	2.8
Coagulation dysfunctions	3	2.8
Others (kidney failure, benign prostate hyperplasia and glaucoma =2; tendinitis; colecystitis, anemia, labyrinthitis, prostate cancer, and hepatitis C=1)	13	12.1

*n≠107 because the elderly reported more than one disease.

Characterization of medication use

The elderly were using a mean of 4.8 (±2.6) medicines. Of the medicines they used, 193 (37.6%) were for the digestive system and metabolism, and 189 (36.8%) were for the cardiovascular system, which were the most consumed, according to the results in Table 3.

Table 3 - Medicine classes according to anatomic groups used by the elderly receiving outpatient treatment. Rio Grande do Sul, Brazil, 2013

Classification	Number of medicines	%
Digestive system and metabolism	193	37.6
Cardiovascular system	189	36.8
Hematopoietic system	41	8.0
Central nervous system	37	7.2
Systemic use	20	3.9
Respiratory system	11	2.1
Skeletal system	7	1.4
Herbal medicines	1	0.2
Others	14	2.8
Total	513	100

With regard to polypharmacy, 52 (48.6%) elderly were using five or more medications. Of the interviewed elderly, 49 (45.8%) reported getting all medications for free from the Unified

Health System (SUS); 11 (10.3%) purchased all their medications, and 47 (43.9%) acquired their medicines from various sources (free from the SUS, purchase and donation).

Characterization of medication adherence

Regarding adherence to their prescribed medication treatment, 93 (86.9%) of the elderly were considered adherent according to the MAT

instrument, and 14 (13.1%) were non-adherent.

The prevalence of nonadherence was higher among older females (13.5%), with 70 years of age or more (25%), living with a partner (14.3%), without paid activity (14.3%), zero to four years of education (14.3%), and income greater than one minimum wage (14.1%), polypharmacy (17.3%) and cognitive impairment (15.6%), as seen in Table 4.

Table 4 – Prevalence of nonadherence to medication in elderly receiving outpatient care. Rio Grande do Sul, Brazil, 2013

Variable	n	Prevalence of nonadherence n (%)	Prevalence ratio	RI*
Gender				
Female	74	10 (13.5)	1	
Male	33	4 (12.1)	1.11	0.37-3.29
Age group				
60-69	71	5 (7.0)	1	
≥70	36	9 (25.0)	0.28	0.10-0.77
Civil status				
With companion	63	9 (14.3)	1	
No companion	44	5 (11.4)	1.25	0.45-3.49
Activity				
Yes	16	1 (6.2)	1	
No	91	13 (14.3)	0.43	0.06-3.11
Education				
0-4 years	56	8 (14.3)	1	
5 or more	51	6 (11.8)	1.21	0.45-3.26
Income				
Up to one minimum wage†	29	4 (13.8)	1	
More than one minimum wage	71	10 (14.1)	0.97	0.33-2.87
Polypharmacy				
No	55	5 (9.1)	1	
Yes	52	9 (17.3)	0.52	0.18-1.46
Mini Mental Exam				
Deficit	45	7 (15.6)	1	
Normal	62	7 (11.3)	1.37	0.52-3.65

* RI=reliability index; †Value of the minimum wage at the time of data collection=R\$ 672.00.

Reasons for nonadherence to prescribed medication therapy by the elderly

All interviewed elderly stated reasons that led them to adhere to prescribed medication therapy: wanting to feel good / maintaining health / staying alive / and quality of life, reported by 67 (62.6%) elderly; controlling the disease and symptoms, 39 (36.5%); medical indication, for 13 (12.2%); due to the family and hoping to heal, by two (1.9%).

Of the 107 elderly, 29 (27.1%) stated reasons that led to nonadherence to prescribed medication therapy: adverse reaction occurrence was reported by nine (8.4%); lack of financial resources by seven (6.5%); lack of availability of the medication at SUS, for five (4.6%); feeling cured and forgetfulness, for three (2.8%); absence of symptoms, long treatment and lack of access to health services, for two people (1,9%).

DISCUSSION

There was a predominance of elderly women (69.2%), a characteristic perceived in other studies as well.³⁻⁴ Some factors explain the difference between the sexes in favor of women such as: cardiovascular protection provided by estrogen, lower mortality rates due to external causes, lower consumption of tobacco and alcohol, as well as increased vigilance over health care throughout the course of life.¹⁵

However, in this study, the women showed a prevalence of nonadherence that was 11% higher than men (PR=1.11). One explanation for the higher nonadherence in women than in men is that they are more prone to changes in mental health.¹⁶ Studies report that the prevalence of depression is higher in elderly females than males, and also females and depression are predictors of nonadherence to medications.¹⁷⁻¹⁸ Nurses should be trained to identify the symptoms of depression early in the elderly.

Regarding the age group, the elderly between 60-69 years (66.4%) were the most frequent, results which were also noted in other research.⁴ In these elderly, the prevalence of nonadherence to medication was 72% lower than in those ≥ 70 years (PR=0.28). In older people, it is important that health professionals/nurses pay more attention to promoting actions that help to maintain their autonomy and independence, as they become more dependent as their age advances.¹⁹ The importance of actions to encourage medication adherence is underscored by the fact that the ability to administer medication is considered an essential skill for maintaining independence in older people.²⁰

There was a predominance of married people (59.8%), a similar finding to another research study with older people receiving outpatient care.² In this study, elderly who lived with a partner showed a 25% higher prevalence of nonadherence than those who were single (PR=1.25). This result was different to that found in the literature, in which the presence of the companion is described as a facilitator of adherence, to the extent that it can help to encourage the correct use of medicines.²¹

Among the elderly people surveyed, 42.1% had an educational level between the first to fourth grades of elementary school, and the prevalence of nonadherence was 21% higher in those with up to

four years of education (PR=1.21). The lower level of education can hinder understanding regarding the use of medications and the adherence to prescribed therapy, resulting in harm to the health of the elderly.⁴ From this perspective, nurses should adapt health care strategies to the educational level of the elderly.

Regarding occupation, 15% of the elderly still received regular salaries. Of these, the prevalence of nonadherence was 57% lower than in those who did not perform work activities (PR=0.43). Performing activities outside the home can contribute to the autonomy and independence of the elderly, to the extent that they remain active and socially integrated.³ Nurses should encourage elderly who are not working to become integrated in community activities and health promotion activities.

The income of the majority of the elderly was more than one to three times the minimum wage, similar to that found in a study on medication adherence in hypertensive elderly.²² Income is important because it determines the supply of health care, social and food needs. Precarious financial conditions and the absence of access to medicines from SUS can influence adherence, due to the difficulty with purchasing the medications.^{2,23} However, in this study, the prevalence of nonadherence was 3% lower in elderly people who had an income up to one minimum wage (PR=0.97).

Of the respondents, 45 (42.1%) showed suggestive results of cognitive impairment, and among these individuals, the prevalence of nonadherence was 37% higher than in those with normal results on the MMSE (PR=1.37). Studies indicate that the presence of cognitive impairment may be associated with nonadherence to medication in older people.²⁰⁻²¹ Thus, it is important that nurses use instruments to assess the cognitive status of older people, for early detection of deficits and prevention of dementia.

Among the elderly, 92.5% had more than one CNCD. The association of diseases can increase the number of medications used, which can interfere with adherence, as it increases the complexity of the therapeutic regimen and adverse risk events.²⁴ As in other studies, arterial hypertension and diabetes mellitus were the CNCDs most present in the respondents.²⁻³ These diseases require different care and, if not properly treated, can lead to the ap-

pearance of complications that can interfere with the autonomy and independence of the elderly.⁴

The respondents used a mean of 4.8 medications. The resulting number is in line with that found in a study with elderly receiving outpatient care in Campinas-SP, Brazil, where the mean was 4.5.² As for polypharmacy, 48.6% used five or more medications and the prevalence of nonadherence was 48% lower in these people (OR=0.52). The use of a greater number of medicines by the elderly can hinder adherence, as it requires more attention, memory and organization for medication administration.²⁰

The most widely used therapeutic class was the medicines that act on the digestive and metabolic system (37.6%), followed by those that operate on the cardiovascular system (36.8%). Studies indicate that these two classes of medications are the most used by the elderly.^{4,5} The most commonly used medicines were in line with the most prevalent CNCDS in the interviewed elderly, which were SH and DM.

Among older people interviewed, 45.8% reported that they could acquire all medications needed, free of charge; this was a similar result to that found in another study.²⁵ The SUS contributed greatly with the organization of programs to ensure people's access to medicines.²⁶ For the treatment of SH and DM, in addition to the availability of medicines, programs that allow the acquisition of medicine at symbolic prices and, more recently, the medicine gratuity assurance in accredited pharmacies were launched.²⁵

In this study, 10.3% of respondents reported using only their own resources to purchase their medicine. Although this number is lower than that reported by other studies, it indicates that there is still a need for further clarification, with the population, about the government programs for free acquisition of medicines, in order to control chronic conditions.²⁵

The prevalence of adherence to prescribed medication therapy was 86.9%. The self-reported degree of adherence is a simple, but subjective, measure of assessing pharmacological monitoring, and may be overestimated by the interviewee. However, the results found in this study were similar to the study of the elderly receiving outpatient care delivered in Campinas-SP, Brazil, in which the prevalence of adherence was 88.5%.²

Among the interviewed elderly, all mentioned reasons that led them to adhere to prescribed medication therapy. The most cited reason was: wanting to feel good/stay healthy / stay alive/have a quality of life (62.6%). A study conducted in the United States, with older people with heart failure, identified the desire to stay healthy as the primary motivation in the decision to take their medication. The desire to stay healthy encompassed, in this research, wanting to feel good, be alive, be out of the hospital and have a good quality of life, similar to the present study.²⁷

The desire to control the disease and the symptoms was reported by 39 (36.5%) elderly as a reason for adhering to the prescribed medication. A study with hypertensive patients, conducted in Taiwan, demonstrated that older people, who suffered from the symptoms of the disease, were more motivated to take medications to prevent this from occurring again and also to control the progression of CNCDS.²⁸

Having a medical indication was the reason stated by 13 (12.2%) elderly for adherence to prescribed medications. Many older people take their medications properly, simply because the physician ordered them.²⁹ Respect and a good relationship with the physician are described as facilitators to adherence in some studies.^{27,29}

Two (1.9%) elderly cited the family as the reason for adherence. Family or caregiver support is essential for compliance with medication therapy, as the aging process may be accompanied by increased dependence for performing instrumental activities of daily life, such as the administration of medications. Thus, problems with the use and administration of medication are minimized when the elderly are accompanied by family members.⁷

Two (1.9%) elderly stated that believing in the possibility of healing was their reason for non-adherence. Many elderly, due to lack of knowledge or personal beliefs think that they can cure their CNCDS themselves. Health education performed by nurses can improve access to the right information, avoiding inadequate understanding of the elderly about their health and disease process.

Of the 107 interviewed, 29 (27.1%) elderly reported reasons that led to nonadherence to prescribed medication therapy. The occurrence of an adverse reaction was the most frequent; similar data were found in other studies, show-

ing the association between adverse reactions and nonadherence to medication.²⁸ The elderly with adverse reactions may cease to take their medications due to fear of new episodes.⁸ The perception about the adverse reactions caused by the use of the medication is an obstacle for adherence, as the fear of presenting it again is reason enough to suspend the use of certain medication without a physician's advice.⁷

In this study, the lack of financial resources was cited by 6.5% of the elderly as a reason for nonadherence to the prescribed medication therapy, and the lack of availability of the medication by SUS, by 4.6%. The elderly receiving outpatient care in Campinas-SP cited these reasons as those that most compromise the acquisition of medicines.² Failure to find all the necessary medicines in the public network, and the lack of money to buy them in the commercial pharmacies, prevented them from following the treatment, and thus they abandoned the prescribed treatment.⁷

Forgetfulness was cited by 2.8% of the elderly as the reason for nonadherence. This reason can be related to cognitive impairment that can occur with aging.²⁰ The use of environmental resources, to remember medication treatment, for example, putting medicines in easily visible places, or adjusting the schedules to their daily routines, can be used to avoid forgetting and facilitate adherence.⁸

Three (2.8%) elderly stated that their feeling cured was a reason for nonadherence, and the absence of symptoms was noted by three (2.8%). Many elderly, when they do not have symptoms of CNCDS, due to the silent character that many of these diseases have, and believing they are cured, eventually stop taking their medications.³⁰ The clarification concerning the chronic nature of these diseases and the importance of treatment to prevent progression can facilitate adherence to medications and other needed care.⁷

Two (2.8%) elderly stated the long period of treatment as a reason for nonadherence to the prescribed medication. Some elderly, at the beginning of treatment, seek to properly follow the prescription, but, over time, and in the presence of some difficulty, decide to follow the treatment in their own manner, considering what is possible, what they can or want to do.³⁰

The lack of access to health services was reported by three (2.8%) elderly as a reason for

nonadherence. The difficulty of access, either due to displacement problems of the elderly or due to a lack of human resources and basic infrastructure in health care services, can contribute to nonadherence to medication. The government and health professionals are responsible for trying to decrease the barriers of the elderly to access health services.

FINAL CONSIDERATIONS

The 107 interviewed elders were mostly female, aged between 60-69 years, white, married, living in the urban area, without a paid activity, with an educational level between the first and fourth grades of elementary education, and monthly income between one and three times the minimum wage.

The most prevalent disease among the elderly was SH, followed by DM. The mean number of daily medicines was 4.8, with the most consumed being those for the digestive, metabolic and cardiovascular systems. Among the elderly, 48.6% had polypharmacy and 86.9% were adherent to prescribed medicine therapy.

The desire for feeling good/healthy/alive/having a good quality of life, and willingness to control the disease and its symptoms were the most cited reasons for adhering to the prescribed medication therapy, and the occurrence of adverse reactions and the lack of financial conditions were the most cited reasons by the elders for nonadherence.

The limitation of this study is the sample selected by convenience. This study characterizes the elderly receiving outpatient care, related to demographic, socioeconomic variables; health and medication use, and demonstrates the factors referred to by them that influence adherence/nonadherence to their prescribed medication treatment.

This information can support the development of nursing care actions to promote adherence to medication therapy for the elderly. We highlight the importance of health education for the elderly, their families and caregivers, as a pillar for strengthening adherence to medication treatment in this population.

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