



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

QUALITY OF LIFE OF ELDERLY ASSISTED BY FAMILY HEALTH TEAMS QUALIDADE DE VIDA DE IDOSOS ACOMPANHADOS POR EQUIPES DE SAÚDE DA FAMÍLIA CALIDAD DE VIDA DE LAS PERSONAS MAYORES ACOMPAÑADAS POR EQUIPOS DE SALUD DE LA FAMILIA

Adenice Gomes Oliveira Ferreira¹, Maria Lourdes Farias Pontes², Edilene Araújo Monteiro³, Sônia Mara Gusmão Costa⁴,
Cleane Rosa Silva⁵, Valéria Peixoto Bezerra⁶

ABSTRACT

Objective: evaluating the quality of life of elderly accompanied by two Family Health Teams and characterizing them as socio-demographic and economic variables. **Method:** a cross-sectional study, which involved 45 subjects of both genders over 60 years old. Data collection was conducted through interviews using an information chip about the respondent, WHOQOL-Bref and WHOQOL-Old. The research project was approved by the Research Ethics Committee, CAAE 0566.0.126.000-10. **Results:** the assessment of QoL of the elderly of this research, according to the WHOQOL-Bref and WHOQOL-Old showed higher scores in the social domain and facet 'sensory abilities'. **Conclusion:** the aging process is dynamic, heterogeneous and individual and requires that professionals and health services consider the various factors that are related to the quality of life of the elderly. **Descriptors:** Elderly; Aging; Quality of Life; Geriatric Nursing.

RESUMO

Objetivo: avaliar a qualidade de vida de idosos acompanhados por duas Equipes Saúde da Família e caracterizá-los conforme as variáveis sociodemográficas e econômicas. **Método:** estudo transversal, do qual participaram 45 sujeitos de ambos os sexos acima de 60 anos. A coleta dos dados foi realizada mediante entrevista utilizando-se uma ficha de informações sobre o respondente, WHOQOL-Bref e WHOQOL-Old. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE 0566.0.126.000-10. **Resultados:** a avaliação da QV dos idosos desta pesquisa, de acordo com o WHOQOL-Bref e WHOQOL-Old, demonstrou maiores escores no domínio social e na faceta 'habilidades sensoriais'. **Conclusão:** o processo de envelhecimento é dinâmico, heterogêneo e individual e requer que os profissionais e os serviços de saúde considerem os diversos fatores que estão relacionados à qualidade de vida do idoso. **Descritores:** Idoso; Envelhecimento; Qualidade De Vida; Enfermagem Geriátrica.

RESUMEN

Objetivo: evaluar la calidad de vida de los ancianos acompañados por dos Equipos de Salud de la Familia y caracterizarlos como variables socio-demográficas y económicas. **Método:** un estudio transversal, que involucró a 45 sujetos de ambos los géneros mayores de 60 años. La recolección de datos se realizó a través de entrevistas utilizando una información sobre el demandado, WHOQOL-Bref y WHOQOL-Old. El proyecto de investigación fue aprobado por el Comité de Ética en la Investigación, CAAE 0566.0.126.000-10. **Resultados:** la evaluación de la calidad de vida de las personas mayores de esta investigación, de acuerdo con el WHOQOL-Bref y WHOQOL-Old, mostró puntuaciones más altas en el campo social y y en la faceta 'habilidades sensoriales'. **Conclusión:** el proceso de envejecimiento es dinámico, heterogéneo e individual y requiere que los profesionales y los servicios de salud consideren los diversos factores que están relacionados con la calidad de vida de las personas mayores. **Descriptor:** Ancianos; Envejecimiento; Calidad de Vida; Enfermería Geriátrica.

¹Nurse Egress, Federal University of Paraíba/UFPB. João Pessoa (PB), Brazil. Email: adne.adenice@gmail.com; ²Nurse, Professor, Department of Nursing, Public Health and Psychiatry, Federal University of Paraíba/UFPB. João Pessoa (PB), Brazil. Email: pontesshalom@gmail.com; ³Nurse, Professor, Department of Nursing, Public Health and Psychiatry, Federal University of Paraíba/UFPB. João Pessoa (PB), Brazil. Email: edileneam06@gmail.com; ⁴Physiotherapist, Master, Federal University of Paraíba/UFPB. João Pessoa (PB), Brazil. Email: soninhagusmao@gmail.com; ⁵Student, Bachelor Course and Degree in Nursing, Federal University of Paraíba/UFPB. João Pessoa (PB), Brazil. Email: cleane_rosas@hotmail.com; ⁶Nurse, Professor, Graduate/Postgraduate Nursing Program, Federal University of Paraíba/PPGENF/UFPB. João Pessoa (PB), Brazil. Email: valeriapbez@gmail.com

INTRODUCTION

In developing countries, there are considered elderly individuals aged 60 or over. Currently, this population segment has increased considerably, especially in developing countries, which requires flexibility in restructuring services that respond better to the demands of this emerging group. Life expectancy until the 30's, from birth, was no more than 50 years old. In developed countries, currently, this expectation exceeds 70 years old and can reach 80. With this increase, there is the desire to reach older ages and with a good quality of life and autonomy.¹⁻²

Due to this increase in the elderly population, the study seeks to understand if the elderly have experienced the aging phase with a good quality of life (QoL). However, this attribute involves multiple meanings, knowledge, experience, individual and collective values, besides being a social construction which covers historical, cultural and social strata or class references. This is an important way to understand this concept to accurately assess the elderly with regard to facing care for it.³

The interest of health professionals by studies of quality of life, every decade has grown and reflected the impact that quality has on people's health.⁴ In 1994, the World Health Organization QoL group (WHO) defined the term quality of life as "the individual's perception of their position in life in the context of culture and value system in which they live and in relation to their goals, expectations, standards and interests".⁵ Since then, this concept has been interpreted in various perspectives as subjective, multidimensional and dynamic, including physical, psychological and spiritual well-being, and social, economic and political.⁶

In view of the development of technology of medicine and the impact of diseases and their treatments, it was necessary to build an assessment tool of QoL of populations. An instrument that has been used worldwide as a basis to calculate the estimate of the quality of life is the World Health Organization Quality of Life (WHOQOL). It allows us to evaluate various aspects of life, both the subjective as the objectives.⁷ When evaluating the quality of life of the human being, it is possible to view the main needs and health care focuses not only of a single being, but also in regard to public health requirements.

Ensuring the promotion and protection of health is granted by the National Policy for Primary Care, characterized by a set of health

actions, both at the individual and the collective. The primary way to reorganize the health system in the country, used by primary care is the Family Health Strategy. Among the various strategic business areas of primary care, it is also evident and growing the practice field area of Health Care of the Elderly.⁷⁻⁸

Healthy aging is a right of all people guaranteed by the Constitution, by means of the Elderly Statute, which states that the elderly have the right to protection of life and health through effective implementation of public social policies that promote healthy aging and a good quality of life,⁹ contributing so that more people achieve more longevity, with the active way of life and the best possible health is the main objective to be achieved in the population aging process.¹⁰

From this perspective, this study aims to:

- Assessing the quality of life of elderly accompanied by two Family Health Teams and characterize them as the sociodemographic and economic variables.

METHOD

This article was extracted from Course Conclusion Work << *Evaluation of quality of life of seniors followed in Basic Health Unit* >> submitted to the Federal University of Paraíba / UFPB, João Pessoa-PB, Brazil, 2011. This is a survey of quantitative cross-sectional design, performed with elderly enrolled in the Family Health Strategy. The study was conducted in a Basic Integrated Health Unit (UBSI), in the municipality of João Pessoa/PB, which tracks user families of the Unified Health System (SUS). The integrated unit comprises four units, which were chosen for the study two health units, one with difficult access due to the distance from the territory of UBSI, and the other closer to the Health Unit as better access to the user.

The study sample was random and attended the elderly aged sixty or over, of both genders, with cognitive conditions to answer the survey instrument and be a resident of the area covered by the relevant Basic Health Unit. This procedure was performed through spare selection of 10% of the population of elderly enrolled in the Primary Care Information System (SIAB), through the month of elderly registration list February 2011. The number of elderly people of both units was obtained from 287 in Unit A and 232 in Unit B, resulting in a sample of 29 elderly from Unit A and 23 from B. Of the 52 elderly in research, questionnaires were applied in 45 (86,54%). Seven waivers were recorded.

Data collection was performed in one moment, in the elderly home, with prior appointment, from February to May 2011, through interviews in which was used a structured instrument to obtain the personal and social information of the elderly, and the Quality of life was measured by the WHOQOL-BREF and WHOQOL-Old. The WHOQOL-abbreviated or WHOQOL-BREF consists of twenty-six items, divided into four domains (physical, psychological, social relationships and environment). Of the 26 questions, two are of general aspect of quality of life, and the other representing each of the 24 facets that make up the original instrument (WHOQOL-100).¹¹

The WHOQOL-Old is a specific tool for assessing the quality of life in older adults and has been validated in Brazil by Fleck in 2006, supported by the WHOQOL Group. It is composed of twenty-four items divided into six facets: sensory, autonomy, death and dying, past, present and future activities, social participation and intimacy.¹² Every facet consists of four items, and the scores can range from four to twenty and have Likert scale of one to five, wherein the scores range from four to twenty points in each domain, or some items are produced in positive mode, in which higher responses indicate better quality of life, and other such negative, in which lower responses indicate poorer quality of life. The transformation to a scale of 0 to 100, where 0 is the worst quality of life, and 100, the best, follow the next rule: $ETE = 6.25 * (EBF-4)$.

Data were entered in the Microsoft Excel program. After coded all variables in a dictionary, has built up a database. Finished typing, data were imported into SPSS (Statistical Package for the Social Sciences) for Windows, version 17.0, for the following analysis: univariate - for qualitative variables we calculated the simple frequency, and quantitative, was applied to Descriptive

statistics such as position measurements (minimum, maximum, average and median) and variability (standard deviation); bivariate - for the analysis of two quantitative variables (QoL domains and facets). To carry out the correlations between measurements, the coefficient of Pearson was applied. When interpreting the positive and negative correlation values between the measurements, it considered the following classification: low: 0 to 0.3; moderate: 0.4 to 0.6; strong: greater than 0.7. The reliability of the instrument was analyzed by the internal consistency using Cronbach's alpha. The reliability of the instrument concerning the consistency of the responses obtained in repeated measurements and the degree of independence between the results when applied at different times.¹³⁻⁴

During all phases of the study, the ethical aspects dealing with research involving human beings were considered, according to the terms of Resolution 196/96 of the Ministry of Health.¹³ In this sense, the study was approved by the Research Ethics Committee of the University Hospital Lauro Wanderley (HULW/UFPB) under the CAAE 0566.0.126.000-10.

RESULTS

The characterization of a population is the first step in the analysis of QoL. Recognizing the main characteristics of the elderly allows us to correlate variables and identify significant data variance. A sample of 45 selected features the following socio-demographic profile: the elderly were entered in age from 60 to over 80 years old; and the average age was of 71 years old (SD = 7,887), the population was predominantly female (75,6%), married (31,2%), literate (77,8%) and mostly retirees or pensioners (86,7%).

Table 1. Socio-demographic and economic characterization of the elderly research participants - João Pessoa, 2011.

Variables	Categories	Nº	%	Average	SD	Median	Variation
Age	60 - 69	19	42,2	71,49	7,887	70.00	62,21
	70 - 79	19	42,2				
	80 and over	7	15,6				
Gender	Female	34	75,6				
	Male	11	24,4				
Marital Status	Single	6	13,3				
	Married	14	31,2				
	Consensual union	3	6,7				
	Separated	2	4,4				
	Divorced	1	2,2				
	Widower	19	42,2				
Reading and writing	Yes	35	77,8				
	No	10	22,2				
Occupation	Retired or pensioner	39	86,7				
	Not retired	6	13,3				
Total		45	100,0				

The results obtained from the analysis of the responses to WHOQOL-BREF are shown in Table 2. The closest result of 100 is better quality of life. The social domain showed a higher average than the other. It assesses personal relationships, support and social support as well as sexual activity. It was observed that the highest average was

referring to the social domain, followed by the psychological domain; and the physical and environmental fields were very similar.

Regarding internal consistency, there was strong consistency in the physical, environmental and psychological domains with Cronbach's alpha values of 0.77, 0.73 and 0.70, respectively.

Table 2. Descriptive analysis and internal consistency of the domains of the WHOQOL-BREF of the elderly of this research - João Pessoa, 2011.

Domains	Physical domain	Psychological domain	Social domain	Environmental domain
Average	62,70	67,78	75,56	62,57
Median	64,28	70,83	75,00	59,37
Standard deviation (SD)	18,95	18,10	13,34	17,02
Minimal	7,14	25,00	41,67	18,75
Maximal	96,43	100,00	100,00	96,88
Cronbach's alpha (α)	0,77	0,70	0,37	0,73

Table 3 presents the results obtained from the analysis of responses to WHOQOL-Old. Domains with highest averages were sensory skills, intimacy, past-present-future. The average value of the total score was similar to other domains.

The domains showed little statistical difference and sensory skills, assessing losses

of hearing, taste, sight, touch and smell showed an average of greater value in relation to others. We observe strong internal consistency rates between the total score ($\alpha = 0.78$) and domains sensory abilities ($\alpha = 0.76$) and social participation ($\alpha = 0.74$).

Table 3. Descriptive analysis and internal consistency of the domains and total score of WHOQOL-Old survey of older people. João Pessoa, 2011.

Domains	HSE	INT	MEM	PS	PPF	AUT	Total Old
Average	76,81	70,83	65,69	63,61	71,53	64,72	68,87
Median	81,25	75,00	75,00	68,75	75,00	68,75	70,83
Minimal	25,00	25,00	0,00	0,00	18,75	12,50	33,33
Maximal	100,00	100,00	100,00	100,00	100,00	100,00	87,50
SD	19,57	19,81	23,82	20,65	19,56	21,70	11,92
Cronbach's alpha	0,76	0,66	0,67	0,74	0,69	0,58	0,78

HSE = sensory skills; INT= intimacy; MEM = death and dying; PS = social participation; PPF = past-present-future; AUT= autonomy
Source: Elderly BHU. João Pessoa, 2011.

There was the Pearson correlation coefficients between the domains of WHOQOL-BREF, the results showed values of strong correlations between the physical and

psychological domains with environmental, moderate correlations between the physical domains with psychological and social, and environmental with social (Table 4).

Table 4. The Pearson correlation coefficient between the domains of the WHOQOL-BREF in elderly research sample. João Pessoa, 2011.

Domains	Physical domain	Psychological domain	Social domain	Environmental domain
Physical	-	0,586**	0,493**	0,755**
Psychological	0,586**	-	0,187	0,701**
Social	0,493**	0,187	-	0,448**
Environmental	0,755**	0,701**	0,448**	-

In Table 5, there was the Pearson correlation between the total score and domains of WHOQOL-Old. The total score showed strong correlations with the domains autonomy and past-present-future, moderate correlations with other domains, except the domain with death and dying, which

presented a weak correlation and statistically not significant. There were moderate correlations between the following areas: autonomy with past-present-future, social participation and intimacy; past-present-future with social participation and intimacy.

Table 5. The Pearson correlation coefficient between the domains and total score of WHOQOL-Old in elderly. João Pessoa, 2011.

Domains	HSE	AUT	PPF	PS	MEM	INT	Total Old
HSE	-	0,208	0,137	0,129	0,056	0,086	0,454**
AUT	0,208	-	0,606**	0,509**	-0,038	0,441**	0,783**
PPF	0,137	0,606**	-	0,632**	-0,111	0,466**	0,769**
OS	0,129	0,509**	0,632**	-	-0,372*	0,239	0,594**
MEM	0,056	-0,038	-0,111	-0,372*	-	0,083	0,222
INT	0,086	0,441**	0,466**	0,239	0,083	-	0,659**

HSE = sensory skills; INT= intimacy; MEM = death and dying; PS = social participation; PPF = past-present-future; AUT= autonomy
Source: Elderly BHU. João Pessoa, 2011.

DISCUSSION

The exponential increase in longevity brings health professionals the challenge to meet and master the factors related to longer life expectancy and the determinants of quality of life, which can intervene with prevention or care.¹⁵⁻⁶

The aging phenomenon can be recognized by narrowing the base and the top of the shift in the age pyramid,¹⁷ which is more significant in females. As noted in other studies, we emphasize that, in this age group, the population is predominantly female.¹⁵⁻⁸ The "feminization of old age" has important implications in health and demands for public policy, for it is they, more than men, who participate in activities and seek health services.¹⁵⁻⁷

Thus, according to the results, the percentage distribution of the elderly population by marital status dominates the state of widowhood, followed by married and who can read and write. Demographic study on aging of the population showed that most elderly widow and had less education.¹⁵⁻⁹

As much as the result of the number of illiterates has not reached even a hundred percent quarter of the sample, this is still a worrying statistic, as the elderly with higher levels of education are more apt to experience old age with better QoL¹⁸, because the difficulty in understanding the guidelines can result in the lack of integration of treatment plans in daily activities, anxiety or

depression arising from incorrect information and/or lack of information.¹⁹

Our sample is predominantly made up of pensioners and the elderly. International research shows clearly that in all ages, the higher socioeconomic status, better health²⁰, because, for most, retirement means loss of income, which imposes a standard of living restructuring, which can cause a feeling low self-esteem.¹⁹⁻²⁰

The analysis of the responses of the domains of WHOQOL-BREF (Table 2) revealed that the social domain had a higher average than the other, corroborating other studies.²¹⁻² This means that for these seniors, participation in daily activities in community, preserved decision making and sexual activity had a greater impact on QoL. Furthermore, the physical, environmental and psychological domains showed greater internal consistency value (α) = 0.77, 0.73 and 0.70, respectively.

The physical size contributes significantly to the quality of life of older people, so we emphasize the importance of considering the functional ability as a major impact factor in the quality of life of the elderly.²¹ Functional capacity currently appears as a new health paradigm for the elderly and healthy aging is seen as a multidimensional interaction between physical and mental health, independence in daily living, social integration, family support and economic independence.^{17,21-2} Thus, the inclusion of social and psychological changes because

spend the elderly are confirmed by literature.^{17,23}

Data concerning the facets of WHOQOL-Old (Table 3), sensory abilities had higher average, which shows that the losses in hearing, in taste, vision, tact and the smell can adversely affect self-esteem and self-care of health of these people, which is why it is necessary to detect these early losses.²⁴

A linear Pearson correlation between the domains of WHOQOL-BREF, which showed a strong association between the level of physical, psychological domains with environmental was performed (Table 4). Considering that the emotional factor assesses if the desire of each to maintain independence and resulting productivity of an active interaction with the environment. Researchers concluded that three main aspects affecting the quality of life: the cognitive and the emotional, health and fitness and social and recreational.²¹ Added to this the relationship between autonomy, past, present and future activities, social participation and intimacy (Table 5).

CONCLUSION

It is expected that the results unveiled and discussed subsidize Gerontology scholars so they can differentiate the importance to recognize of heterogeneity of the elderly population with regard to individuality, when assessing the quality of life. Professionals and health services should consider the multidimensional context of life of the elderly in order to prevent to subsequently maintain the independence, autonomy, social inclusion and improvement of quality of life.

REFERENCES

1. Pereira RJ, Cotta RMM, Franceschini SCC, Ribeiro RCL, Sampaio RF, Priore SE, et al. Contribuição dos domínios físico, social, psicológico e ambiental para a qualidade de vida global de idosos. Rev psiquiatr Rio Gd Sul [Internet]. 2006 Jan/Apr [cited 2012 Mar 11];28(1):27-38. Available from: http://www.revistapsiqrs.org.br/administracao/arquivos/contribuicao_dominios_fisicos_28_01_06.pdf.
2. Carolino JA, Soares ML, Cândido GA. Envelhecimento e cidadania: possibilidades de convivência no mundo contemporâneo. Rev Qualit@s [Internet]. 2011 [cited 2012 May 10];11(1): 1-11. Available from: <http://revista.uepb.edu.br/index.php/qualitas/article/view/1182/597>
3. Oliveira MR, Orsini M. Escalas de avaliação da qualidade de vida em pacientes brasileiros após acidente vascular encefálico. Rev Neurociênc [Internet]. 2008 [cited 2012 oct 12];16 (1): 1-7. Available from: http://www.unifesp.br/dneuro/neurociencias/235_revisao.pdf.
4. Pazos A, Dopico L. Life quality and the nursing interventions for patients with chronic skin lesion - a prospective study. Online braz j nurs [Internet]. 2006 Aug [cited 2012 Oct 27];5(2):]about 5 p.].- Available from: <http://www.objnursing.uff.br/index.php/nursing/article/view/358/82>
5. WHOQOL Group. The world health organization quality of life assessment (WHOQOL): position paper from the world health organization. Soc Sci med [Internet]. 1995 [cited 2013 Jan 14];41(10):1403-9. Available from: <http://www.sciencedirect.com/science/article/pii/027795369500112K>
6. Castro MG, Oliveira MS, Miguel AC, Araújo RB. WHOQOL-BREF propriedades psicométricas em uma amostra de fumantes. Rev bras psiquiatr [Internet] 2007. [cited 2012 oct 23]; 29(3). Available from: http://www.scielo.br/scielo.php?script=sci_issuetoc&pid=1516-444620070003&lng=en&nrm=iso
7. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde, 2006. 10-1 p. (Série A. Normas e Manuais Técnicos) (Série Pactos pela Saúde, v.4).
8. Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. Brasília; 2006. 33 p.(Série B. Textos Básicos de Saúde).
9. Brasil. Brasil. Estatuto do Idoso. Lei nº 10.741, de 1º de outubro de 2003. Dispõe sobre o Estatuto do Idoso e dá outras providências. Brasília [Internet]. 2003 [cited 2013 Jan 10]. Available from: http://www.planalto.gov.br/ccivil_03/leis/2003/L10.741compilado.htm
10. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Envelhecimento e saúde da pessoa idosa. Brasília: Ministério da Saúde; 2007. 7 p. (Cadernos de Atenção Básica; n. 19, Série A. Normas e Manuais Técnicos).
11. Fleck MPA, Louzadas S, Xavier M, Chachamovich E, Vieira G, Santos L, et al. Aplicação da versão em português do instrumento abreviado de avaliação da qualidade de vida "WHOQOL-bref". Rev saúde pública [Internet]. 2000 [cited 2012 June 13];34(2):178-83. Available from:

http://www.scielo.br/scielo.php?pid=S0034-89102000000200012&script=sci_arttext

12. Fleck MPA, Chachamovich E, Trentini C. Projeto WHOQOL-OLD: método e resultados de grupos focais no Brasil. *Rev saúde pública* [Internet]. 2003 Dec [cited 2012 June 12];37(6):793-9. Available from: <http://www.scielo.br/pdf/rsp/v37n6/18024.pdf>.

13. Brasil. Ministério da Saúde. Conselho Nacional de Saúde, Comissão Nacional de Ética em Pesquisa em Seres Humanos. Resolução Nº 196, de 10 de outubro de 1996: diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos. Brasília: Ministério da Saúde; 1996.

14. Figueiredo DBF, Silva JAJ. Desvendando os mistérios do coeficiente de correlação de Pearson (r). *Rev Política Hoje* [Internet]. 2009 [cited 2012 June 12];18(1):115-45. Available from:

www.ufpe.br/politica/hoje/index.php/politica/article/download/6/6

15. Costa MFL, Camarano AA. Demografia e epidemiologia do envelhecimento no Brasil. In: Moraes EM. *Princípios básicos de geriatria e gerontologia*. Belo Horizonte: Coopmed; 2008. p. 3-19.

16. Fleck MPA, Chachamovich E, Trentini C. Development and validation of the Portuguese version of the WHOQOL-OLD module. *Rev saúde pública* [Internet]. 2006 [cited 2013 Oct 10];40(5):785-91. Available from: http://www.scielo.br/scielo.php?pid=S0034-89102006000600007&script=sci_arttext

17. Braga MCP, Casella MA, Campos MLN, et al. Qualidade de vida medida pelo WHOQOL-BREF: estudo com idosos residentes em Juiz de Fora/MG. *Rev APS* [Internet]. 2011 [cited 2013 Oct 10];14(1): 93-100. Available from: <http://www.aps.ufjf.br/index.php/aps/article/view/965/450>

18. Maués CR, Paschoal SMP, Jaluul O, França CC, Jacob Filho W. Avaliação da qualidade de vida: comparação entre idosos jovens e muito idosos. *Rev Bras Clin Med* [Internet]. 2010 [cited 2013 Nov 10];8(5):405-10. Available from: <http://files.bvs.br/upload/S/1679-1010/2010/v8n5/007.pdf>

19. Gutierrez BAO, Auricchio AM, Medina NVJ. Mensuração da qualidade de vida de idosos em centros de convivência. *J Health Sci Inst* [Internet]. 2011 [cited 2013 Oct 28];29(3):186-90. Available from: http://www.unip.br/comunicacao/publicacoes/ics/edicoes/2011/03_jul-set/V29_n3_2011_p186-190.pdf

20. Neri AL. Qualidade de vida na velhice e subjetividade. In: Neri AL. *Qualidade de vida*

na velhice: enfoque multidisciplinar. Campinas: Alínea; 2007. p. 13-59.

21. Melo FA, Torres VM, Marino CL, Vieira SC. Qualidade de vida e perdas dentárias em adultos com hipertensão e diabetes. *J Nurs UFPE on line* [Internet]. 2013 July [cited 2012 Oct 28];7(7):4696-703. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/4008>

22. Farenzena WP, Argimon IL, Moriguchi E, Portuguese MW. Qualidade de vida em um grupo de idosos de Veranópolis. *Rev Kairós* [Internet]. 2007 [cited 2012 Nov 13];10(2):225-243. Available from: <http://revistas.pucsp.br/index.php/kairós/article/view/2600/1654>

23. Fleck MPA, Chachamovich E, Trentini CM. Projeto WHOQOL-OLD: método e resultados de grupos focais no Brasil. *Rev saúde pública* [Internet]. 2003 [cited 2013 nov 13];37(6):793-9. Available from: <http://www.scielo.org/pdf/rsp/v37n6/18024.pdf>

24. Soares MBO, Tavares DMS, Dias FA, Diniz MA, Geib S. Morbidades, capacidade funcional e qualidade de vida de mulheres idosas. *Esc Anna Nery Rev Enferm* [Internet]. 2010 [cited 2013 Nov 14]; 14(4):705-711. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452010000400008

Submission: 2014/05/12

Accepted: 2015/07/27

Publishing: 2015/08/15

Corresponding Address

Maria de Lourdes de Farias Pontos
Universidade Federal da Paraíba
Departamento de Enfermagem, Saúde Pública e Psiquiatria
Cidade Universitária
CEP 58051-900 – João Pessoa (PB), Brazil