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ORIGINAL ARTICLE

SOCIODEMOGRAPHIC PROFILE AND SOCIAL SUPPORT OF ELDERLY PERSONS IN PRIMARY CARE

PERFIL SOCIODEMOGRÁFICO E SUPORTE SOCIAL DE IDOSOS NA ATENÇÃO PRIMÁRIA

PERFIL SOCIODEMOGRÁFICO Y SOPORTE SOCIAL DE ANCIANOS EN LA ATENCIÓN PRIMARIA

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ABSTRACT

Objective: to investigate the sociodemographic profile and social support network of the elderly. ***Method:*** quantitative, descriptive study with 130 elderly family health users. A questionnaire was used for the sociodemographic profile and the Minimum Map of Relations of the Elderly. Descriptive statistical analysis and Pearson's Chi-square test, ANOVA 1 criterion, Mann-Whitney or Kruskal-Wallis were presented in tables. ***Results:*** the prevalence of the female sex (57.7%), with a mean age of 70.5 years, was higher among married elderly people (47.7%) and with children (95.4%). Regarding schooling, 59.2% had primary education incomplete. The family proved to be the best social support, while social services and health, the worst. ***Conclusion:*** the elderly have great family social support and small social support from friends, community and health services. Thus, studies are needed to implement strategies aimed at increasing the social support of the elderly in order to promote healthy aging. ***Descriptors***: Aged; Community Health Nursing; Nursing Care; Comprehensive Health Care; Primary Health Care; Social Support.

RESUMO

Objetivo*:** investigar o perfil sociodemográfico e a rede de suporte social dos idosos. ***Método*:** estudo quantitativo, descritivo, com 130 idosos usuários da saúde da família. Utilizaram-se um questionário para o perfil sociodemográfico e o Mapa Mínimo de Relações do Idoso. Realizaram-se a análise estatística descritiva e os testes estatísticos Qui-quadrado de Pearson, ANOVA 1 critério, Mann-Whitney ou Kruskal-Wallis apresentados em tabelas. ***Resultados*:** obtiveram-se a prevalência do sexo feminino (57,7%), com idade média de 70,5 anos, de idosos casados (47,7%) e com filhos (95,4%). Quanto à escolaridade, 59,2% tinham o primário incompleto. A família revelou ser o melhor suporte social, enquanto os serviços sociais e de saúde, os piores. ***Conclusão: os idosos possuem grande suporte social familiar e pequeno suporte social de amigos, comunidade e serviços de saúde. Dessa forma, são necessários estudos voltados para a implementação de estratégias que visem ao aumento do suporte social dos idosos com vistas à promoção do envelhecimento saudável. ***Descritores:*** Idoso; Enfermagem em Saúde Comunitária; Cuidados de Enfermagem; Atenção Integral à Saúde do Idoso; Atenção Primária à Saúde; Apoio Social.

RESUMEN

Objetivo: investigar el perfil sociodemográfico y la red de soporte social de los ancianos. ***Método:*** estudio cuantitativo, descriptivo, con 130 ancianos usuarios de la salud de la familia. Fueron utilizados uno cuestionario para el perfil sociodemográfico y el Mapa Mínimo de Relaciones del Anciano. Se realizaron la análisis estadístico descriptivo y las pruebas estadísticas Qui-cuadrado de Pearson, ANOVA 1 criterio, Mann-Whitney o Kruskal-Wallis, presentados en tablas. ***Resultados:*** se obtuvieron la prevalencia del sexo femenino (57,7%), con edad media de 70,5 años, de ancianos casados (47,7%) y con hijos (95,4%). En cuanto a la escolaridad, el 59,2% tenía la enseñanza primaria incompleta. La familia se reveló ser el mejor soporte social, como los servicios sociales y de salud, los peores. ***Conclusión:*** los ancianos poseen gran soporte social familiar y, pequeño soporte social de amigos, comunidad y servicios de salud. De esta manera, son necesarios estudios dirigidos a la implementación de estrategias que apunten al aumento del soporte social de las personas mayores con el fin de promover el envejecimiento saludable. ***Descriptores***: Anciano; Enfermería em Salud Comunitaria; Atención de Enfermería; Atención Integral de Salud; Atención Primaria de Salud; Apoyo Social.

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INTRODUCTION

There was a regular demographic pattern in Brazil in the 1940s and 1950s: levels of fertility and mortality remained small. Since 1960, significant reductions in fertility levels have begun, which, when compared to other countries, show Brazil as the protagonist of one of the world's fastest transitions. The Brazilian demographic pattern was modified, presenting a reduction in the fertility rate, which slowed the growth of the number of children and adolescents, while increasing the population in active age and the elderly population.[1]

Human aging is characterized as an essential process of life, uninterrupted, inherent in human development, in which the various social and personal meanings are marked by human trajectory. It should not be seen as an end, but as a period of continuity of life with its own characteristics, requiring public policies that promote the improvement of the quality of life of the elderly.[1]

The risk of vulnerability and social isolation associated with the elderly led the World Health Organization (WHO) to recognize social support in the form of a network as an important factor in the prevention of social exclusion and the necessary measure to promote healthy aging.[2]

Defined as the totality of resources that a person receives from other people, social support is considered one of the most important predictors of health and well-being, from infancy to old age, and results from social relations and the establishment of interpersonal bonds. Formal social support comprises professionals from the public sectors, while the informal includes family members, friends and neighbors.[3]

In basic care, nurses can seek and monitor the resources used by the elderly as support that provide quality aging. In order for the social support network to exist and function properly, the community must be prepared for the task of caring for the elderly.

In this context, the following question was defined: What is the socio-epidemiological profile of the elderly that use basic care? How is the social support network of these elderly people composed? How the social support network of elderly residents in urban and rural areas is formed?

OBJECTIVE

- To investigate the sociodemographic profile and the social support network of the elderly.

METHOD

A quantitative study of the descriptive type, carried out with the Family Health Program (PSF) in the municipality of Benevides (PA), Brazil. Between 2000 and 2010, the local aging rate ranged from 3.36 to 4.46%, from the mean age of 66,5 years, in 2000, to 72.9 years, in 2010, approaching the national life expectancy, which is 73.9 years.[4]

The studied population was 130 elderly people accompanied by PSF. The sample size was determined by the random sample, stratified by health unit of the family and by sex,[5] with a sampling error of 4.40%. Initially, according to the statistical calculations, 51 elderly of the urban unit (Medice) and 14 of the rural unit (Terceira Travessa) were selected. However, in order to provide a paired analysis between the units and safety margin for the statistical calculations, it was chosen to match the samples for 65 elderly in each unit.

Data were collected by selecting two units: one in the urban area (family health unit: Médice) and the other in the rural area (family health unit: Terceira Travessa).

Inclusion criteria were: elderly, aged 60 years or older, cared for in the family health units and / or in the homes of the elderly attached to the units. With the help of community health agents, who identified the elderly in their list of users, a larger number of families with older persons.

Data were collected from January 2015 to January 2016. A questionnaire was applied on the socio-epidemiological profile and the minimum map of relationships of the elderly - MMRI (Sluzki's Minimal Relations Map).[6] MMRI is an instrument of registration of social support network evaluation. This map registers all the people who are support: those who visit and / or companions the elderly, in addition to those who help with financial resources, household chores and personal care.[3-7] These people are recorded on the map in their respective quadrants family, friends, community, and social or health service relationships. In each quadrant, one of the three circles, around a central point representing the elderly, is pointed out, those persons with nearer contact relations occurring at least once a week (often) in the innermost circle; in the middle circle are marked personal relationships with encounters that happen at least once a month (infrequent); in the outer circle, the occasional contacts, rarer, such as once a year, for example.[3]

The size of the social support network is measured by the MMRI registration number of supportive people whose answers represent the self-perception of the elderly. The network is classified as small, medium and large, respectively, with zero to two people, with three to five people and with more than six people. In terms of composition, the breadth of meaningful relationships in the network is represented in the four quadrants of the map: family members; friends; community and social and health services. In terms of contact frequency, the intensity is evaluated by the number of people assigned in the three circles of highest, medium and low frequency of contacts and function performed.[3]

For the analysis of the data, the descriptive statistics were applied to obtain the absolute frequency, the percentage, the mean, the standard deviation, the median, minimum and maximum quartiles, and 95% Confidence Intervals (CI) to characterize the variables. The statistical tests used were the Pearson's Chi-square or Fisher's Test and the ANOVA tests 1 criteria (normal distribution and multivariate analysis), Mann-Whitney or Kruskal-Wallis (non-numerical distribution). Comparisons with p values less than 0.05 were considered statistically significant.

The research project was submitted to the Human Research Ethics Committee of UNIFESP, in São Paulo, which approved it and whose document is registered under no. 990,544 and CAAE: 41557915.8.0000.5505. Ethical principles such as autonomy, respect, beneficence or maleficence and confidentiality were considered. The elderly who accepted to participate in the study signed the Free and Informed Consent Form.

RESULTS

Among the 130 elderly, the majority of the elderly were female (57.7%), aged between 60 and 69 years (53.8%), mean age of 70.5 years, married (47.7%). As to the presence of children, it was possible to observe the predominance of the elderly who had children (95.4%). With regard to schooling, the majority was represented by incomplete primary education (59.2%).

Table 1. Sociodemographic profile of the elderly served by the Family Health Program. Benevides (PA), Brazil, 2016.

Variables	n	%	IC95%
Sex			
Male	55	42.3	33.7 - 51.3
Female	75	57.7	48.7 - 66.3
Age Group			
Young elderly(60 to 69 years)	70	53.8	44.9 – 62.6
Middle elderly (70 to 79 years)	37	28.5	20.9 - 37
Elderly (80 or +)	23	17.7	11.6 – 25.4
Average ± Standard deviation	70.5 ± 8.9 anos	69.0 – 72.0 anos	
Marital status			
Maried	62	47.7	38.9 – 56.6
Widower	42	32.3	24.4 – 41.1
Divorced/Separated	12	9.2	4.9 – 15.6
Single	14	10.8	6.0 – 17.4
Presence of children			
No	6	4.6	1.7 – 9.8
Yes	124	95.4	90.2 – 98.3
Average ± Standard deviation	5.5 ± 3.5 filhos	4.8 – 6.1 filhos	
Level of education			
None	28	21.5	14.8 – 29.6
Incomplete elementar school	77	59.2	50.3 - 67.8
Complete elementar school/ Middle school	16	12.3	7.2 – 19.2
Highschool/Higher education	9	6.9	3.2 - 12.7

Table 2 compares the sources of social support contained in the map quadrants - MMRI among the elderly in the urban and rural units. The averages of the number of people in the family social support for the elderly were 6.82 in the urban area and 18.26 in the rural area. Social support in the number of people coming from the Social Services and Health, for the elderly of the urban unit, was 0.05, and the rural unit was 0.28.

Table 2. Comparison of the Minimum Map of Relations of the Elderly - MMRI, among the elderly of urban and rural units, assisted by the Family Health Program. Benevides (PA), Brazil, 2016.

Social support quadrants	Descriptive analysis of MMRI							
	Unit	n	Average	Standard deviation (+dp)	Min	Median	Máx	p-value
Family	Urban	65	6.82	3.65	1.00	7.00	16.00	<0.0001*
	Rural	65	18.26	4.23	3.00	20.00	21.00	
	General	130	12.54	6.96	1.00	13.00	21.00	
Friends	Urban	65	1.25	2.02	0.00	0.00	9.00	0.2740
	Rural	65	0.86	1.97	0.00	0.00	7.00	
	General	130	1.05	2.00	0.00	0.00	9.00	
Comunity	Urban	65	0.57	1.63	0.00	0.00	9.00	0.8209
	Rural	65	0.51	1.46	0.00	0.00	9.00	
	General	130	0.53	1.54	0.00	0.00	9.00	
Social and Health Services	Urban	65	0.05	0.21	0.00	0.00	1.00	0.1101
	Rural	65	0.28	1.07	0.00	0.00	6.00	
	General	130	0.16	0.78	0.00	0.00	6.00	
Total	Urban	65	8.68	4.10	1.00	9.00	18.00	<0.0001*
	Rural	65	19.91	3.93	4.00	21.00	27.00	
	General	130	14.29	6.91	1.00	15.00	27.00	

* Statistically significant difference (ANOVA 1 criteria).

In relation to the Social Support network registered in the MMRI as to the frequency in which the contacts of people with the elderly occur, in the Family support, the elderly of the urban unit had a small frequency of contact with people (2,6) while in the rural unit , the frequency of contacts (6.3) was great. Support from the Social and Health Services for the elderly in both areas was almost non-existent (Table 3).

Table 3. Frequency classification of contacts registered in the MMRI of the elderly of the urban and rural units served by the Family Health Program. Benevides (PA), Brazil, 2016.

Social support network Frequent contact (First Circle-MMRI)		Average	±sd	median	min-max	classification
GENERAL	Family	4.4	2.3	4.5	1 a 9	Average
	Friends	0.43	0.74	0	0 a 3	Small
	Comunity	0.25	0.71	0	0 a 4	Small
	Health services	0.08	0.32	0	0 a 2	Small
URBAN	Family	2.6	1.3	2	1 a 9	Small
	Friends	0.52	0.77	0	0 a 3	Small
	Comunity	0.20	0.56	0	0 a 3	Small
	Health services	0	0	0	0	Small
RURAL	Family	6.3	1.4	7	1 a 8	Big
	Friends	0.34	0.69	0	0 a 2	Small
	Comunity	0.29	0.82	0	0 a 4	Small
	Health services	0.15	0.44	0	0 a 2	Small

It was evidenced that, regardless of the level of proximity of the contacts of people with the elderly, those of the urban unit are smaller than the contacts of the rural unit, according to table 4.

Table 4. Descriptive analysis of the MMRI of the elderly of the urban and rural units, attended by the Family Health. Benevides (PA), Brazil, 2016.

Proximity	Units	n	Average	Standard deviation (+sd)	Min	Mediani	Max	p-value
Frequent contact	Urban	65	3.28	1.54	1.00	3.00	9.00	
	Rural	65	7.06	1.52	1.00	7.00	11.00	<0.0001*
	General	130	5.17	2.43	1.00	6.00	11.00	
Little frequent	Urban	65	2.66	1.56	0.00	3.00	6.00	
	Rural	65	6.45	1.46	1.00	7.00	9.00	<0.0001*
	General	130	4.55	2.42	0.00	5.00	9.00	
Rare contact	Urban	65	2.74	1.81	0.00	3.00	7.00	
	Rural	65	6.40	1.44	1.00	7.00	9.00	<0.0001*
	General	130	4.57	2.46	0.00	5.00	9.00	

* Statistically significant difference (ANOVA 1 criteria/ Mann-Whitney Test).

DISCUSSION

A predominance of females was observed in this study, which corroborates the situation found in well-known studies on the prevalence of elderly women in the general population.[4,8] This result is in agreement with a study carried out in Portugal, which ranks fifth among countries older Europeans.[9]

As to age, the results found here are similar to those in the literature, whose averages range from 69.0 to 73.0 years.[8,10] In a comparative study with elderly people from urban and rural areas, conducted in Minas Gerais, rural areas were prevalent in the urban area (40% and 37%, respectively), having, as a general average, the age of 72 years.[11] In a study carried out in Mexico, it was observed that 41% of the elderly were aged between 60 and 65 years, [12] similar to that of this study, demonstrating the prevalence of young people.

In relation to the marital status, the majority were married, followed by widowers, a result that is corroborated by a national study in which 39.9% were married elderly, followed by 36.3% of widowers.[13] However, there are dissonant studies whose results reveal a majority of unmarried elders.[14] In the same line of research, in a survey carried out in Mexico, there was a predominance of elderly widowers (50%), followed by married couples (40%).

As for the number of children of the elderly, the average was 4.8 to 6.1 children. This result converges with international studies on the elderly. In European countries, such as Portugal, [2] it was found that the elderly have, on average, one child (50.6%), with a higher education level, which may justify the reduced number of children. In this way, the larger number of children can provide informal support to the elderly population.

The low level of schooling found in this study was similar to that of other national studies[3,16] and affirms the schooling of the elderly in the Amazonian context in 52.4% with incomplete secondary education.[17] It also corroborates with these results, a study carried out in Coimbra (Portugal) in which the average prevalence of 51.4% to 45.6% of the elderly with only four years of schooling prevailed.[18]

The results of this study on social support (SS) showed that the family, in both urban and rural areas, is an important source of support and meets international studies.2 Family members are the ones who help the most and constitute strong sources of informal support for the elderly, and can count on the support available to assist in caring, listening, talking, advising, informing and resolving situations of impasse.[9,19]

The SS that falls on the family of the rural area is high, since it is believed that the children grow, marry and constitute their families, however, they continue to live near each other, facilitating the relation for the daily care, unlike what occurs in the urban area. Thus, the family constitutes an important protection factor in the aging process.[2,16]

Other social supports, such as friends and community members, were small, between zero and two people, depriving the elderly of this privilege, since national studies have indicated positive impacts of this support on the elderly state of mind and well-being.[20]

International studies[9] have shown that social support resulting from a link with professionals in health services is of

fundamental importance in the constitution of social support networks in the attention to the elderly population. However, in national studies,[21] the lack of this link with health services is similar to the one found in this study, since it emphasizes the need to operationalize public social and health policies that are in keeping with the real demands of the elderly population according to socio-geographical contexts specific. A study carried out in France[22] revealed that the lack of Social Support in relation to the absence of social relations and bonds proved to be a predictor of poor perception for the self-reported health condition of the elderly.

Although the municipality serves 92-96% of the elderly population in primary care, Benevides has shown a reduced social support network in the face of the growing number of elderly people dependent on daily care for both the social and health care sectors. The study presented a health indicator that shows that the elderly user service is below their needs from the perspective of the elderly themselves, who are not being cared for in their aging process, nor aiming for a healthy aging.

This study had limitations regarding the few studies about social support of the elderly in the Brazilian Amazon region, thus making it difficult to compare the results. However, it shows that social support must be the object of research and improvement of actions during the aging process, especially in health services and in the community.

CONCLUSION

The study investigated the sociodemographic profile and the social support of the elderly of the Amazon attended by the Family Health program and its relationship with the social support network. It was observed the predominance of elderly women, married, with children and low educational level. The high number of widowers was highlighted, evidencing an eventual decrease in traditional family support.

The social support network of the elderly was restricted and basically composed of members of their own family, with very few friends and almost no members of the community. The elderly do not perceive affective bonds between the professionals of the network of social and health services who attend them and the community, nor with themselves, who receive care directly.

It is believed that this study may contribute to research on aging and the social support network considering the accelerated process of Brazilian population aging. These findings require that a number of measures be taken, such as: reviewing policies and programs geared to the elderly population appropriate to each particular socio-geographical context, including a broad dimension of lifelong care as one ages, including promoting healthy aging in the elderly autonomous and independent; the maintenance of control of the conditions of chronicity proper to old age and the support to the continued and prolonged care of elderly people in increasing embryo until the end of their earthly life.

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