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RESEARCH

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CHARACTERIZATION OF THE HEALTH PROFILE OF ELDERLY REGISTERED PERSONS IN PRIMARY HEALTH CARE

Caracterização do perfil epidemiológico de idosos cadastrados na atenção primária à saúde

Caracterización del perfil epidemiológico de ancianos registrados en la atención primaria a la salud

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ABSTRACT

Objective: To characterize the epidemiological profile of elderly registered in Primary Health Care in the city of Pombal, Paraíba. **Method:** Cross-sectional study with 307 elderly registered in Primary Health Care, used the collection instrument prepared by the Research Group of the Center for Studies and Research on Care and Human Development, Federal University of Minas Gerais. **Results:** Female elderly (28,3%), married / stable union (47,9%), Catholics (85,3%), non-working (90,6%), retired (91,2%) prevailed, literate (57,0%), without consuming alcohol (90,2%), without smoking (87,6%) and with health problems (90,9%). **Conclusion:** Notoriously, it is essential to carry out measures aimed at health promotion and prevention of damage and injuries, as well as maintenance and rehabilitation of health, according to the principles of equity and comprehensive care, especially with regard to Primary Care the health.

DESCRIPTORS: Primary health care; Health care; Chronic non communicable diseases; Population ageing; Elderly.

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RESUMO

Objetivo: Caracterizar o perfil epidemiológico de idosos cadastrados na Atenção Primária à Saúde do município de Pombal, Paraíba. **Método:** Estudo transversal, com 307 idosos cadastrados na Atenção Primaria à Saúde, utilizou-sedo instrumento de coleta elaborado pelo Grupo de Pesquisa do Núcleo de Estudos e Pesquisas em Cuidado e Desenvolvimento Humano, da Universidade Federal de Minas Gerais. **Resultados:** Prevaleceu idosos do sexo feminino (28,3%), casado/união estável (47,9%), católicos (85,3%), que não trabalham (90,6%), aposentados (91,2%), alfabetizados (57,0%), sem consumir bebida alcoólica (90,2%), sem fumar (87,6%) e com problemas de saúde (90,9%). **Conclusão:** Notoriamente, torna-se imprescindível a realização de medidas voltadas a promoção da saúde e prevenção de danos e agravos, bem como manutenção e reabilitação da saúde, de acordo com os princípios da equidade e integralidade do cuidado, principalmente no tocante a Atenção Primária à Saúde.

DESCRITORES: Atenção primária à saúde; Atenção à saúde; Doenças crônicas não transmissíveis; Envelhecimento populacional; Idosos.

RESUMEN

Objetivo: Caracterizar el perfil epidemiológico de adultos mayores registrados en Atención Primaria de Salud en la ciudad de Pombal, Paraíba. **Método:** Estudio transversal con 307 adultos mayores registrados en Atención Primaria de Salud, se utilizó el instrumento de recolección preparado por el Grupo de Investigación del Centro de Estudios e Investigación en Atención y Desarrollo Humano, Universidade Federal de Minas Gerais. **Resultados:** Prevalecieron mujeres de edad avanzada (28,3%), casadas / unión estable (47,9%), católicas (85,3%), no trabajadoras (90,6%), jubiladas (91,2%), alfabetizados (57,0%), sin consumir alcohol (90,2%), sin fumar (87,6%) y con problemas de salud (90,9%). **Conclusión:** Notoriamente, es esencial llevar a cabo medidas dirigidas a la promoción de la salud y la prevención de daños y lesiones, así como al mantenimiento y rehabilitación de la salud, de acuerdo con los principios de equidad y atención integral, especialmente con respecto a la Atención Primaria la salud.

DESCRIPTORES: Atención primaria a la salud; Cuidado de la salud; Enfermedades crónicas no transmisibles; Envejecimiento de la población; Ancianos.

INTRODUCTION

Population aging has progressed rapidly around the world. In Brazil, this process has occurred quickly and intensely, with an elderly population with a low socioeconomic level and a high prevalence of Chronic Noncommunicable Diseases (NCDs),[1] a situation that directly impacts the well-being of this population segment.

It is noteworthy that this conjuncture is reflected in the Health Care Network (RAS), in which the multiprofessional team, services and the community experience new challenges towards understanding the specificities of the elderly, who have required differentiated actions, from the perspective of promotion, protection and recovery of health, in a tactical and structured way, aiming at interventions capable of maintaining the autonomy and independence of the elderly, and reducing the substantial burden of health care services and national economy.[2]

One of the biggest challenges of the Unified Health System (SUS) is to adapt and train the service network, especially Primary Health Care (PHC), to serve the elderly population and the specificities of their health conditions. Because, it is the scenario of attention of greater quantity of the sexagenarian public, which commonly seeks outpatient care and / or monitoring of diseases, such as NCDs, which today constitute a relevant public health problem.[3].

Considering the social, cultural and economic heterogeneity of Brazil, marked by a plurality of conditions, mainly with regard to health, it finds one of its greatest challenges in the elderly population, since that of considering this population is its demographic identity.

The conditions of aging in rural areas, mainly in the region of northeastern Brazil, marked by factors such as poverty, isolation, migration of young people to urban areas in search of jobs and better living conditions, thus prevailing, only the elderly in the countryside, above all, with chronic health problems and difficult access to health care services, requiring more effective and well developed action by the HCN.[4]

Thus, it is understood that studies and research that early identify the vulnerabilities that condition the health of the elderly are essential, for an effective promotion of health and prevention of diseases, for enabling a quick and adequate management of their needs.

Therefore, the objective was to characterize the epidemiological profile of elderly people registered in Primary Health Care in the municipality of Pombal, Paraíba.

METHOD

Cross-sectional correlational analytical study, developed with elderly people registered at the PHC in the municipality of Pombal, Paraíba, from January to March 2017.

The municipality of Pombal belongs to the immediate geographical region of the state of Paraíba, its coverage area is 888.807 km^2, with an estimated population for 2018 of 32,749 inhabitants.5 Its PHC service has 12 Basic Health Units (UBS) distributed in its rural and urban territorial extension, with an increasing coverage rate from 2001 to 2006, which changed to (100%) from 2007 to 2016.[6]

The population was represented by 2,972 elderly people aged 65 and over. For the sample calculation, the random sampling process for finite populations was adopted with a significance level of (95%) and sampling error equal to five percent, which established one (n) equivalent to 307 elderly people, distributed proportionally among the 12 UBS for the purpose of ensuring proportional representation.

After this distribution, the addresses of the elderly were chosen by random drawing, so that everyone had the same possibility of being included in the sample. Then, the visits to the homes were scheduled and took place in the company of the Community Health Agent (CHA), responsible for a certain area.

In this study, elderly people aged 65 and over were included and registered at UBS for at least six months, considering only one elderly person per residence. Elderly people who were absent from the residence for three visits and were hospitalized were excluded.

The instrument used for data collection was developed by the Research Group for Studies and Research in Care and Human Development at the Federal University of Minas Gerais (UFMG), with variables that assessed the demographic profile (age, gender, religion, marital status , occupation, income, housing, education); and clinical (alcohol consumption, smoking, physical activity, clinical history), based on the expertise of the researchers.[7]

The collected data were entered by double entry in an electronic database. Then, they were submitted to descriptive statistical analysis with the aid of the Statistical Package for the Social Sciences (SPSS) version 2.0, focusing on the absolute (N) and relative (%) frequency.

The project was approved by the UFMG Research Ethics Committee, under CAAE: 62429616.0.0000.5149, opinion number 1.870.226, as recommended by Resolution 466/12 of the National Health Council,[8] after prior authorization from the health secretary, responsible for Municipality's PHC.

RESULTS

As the characters of demographic profile, of 307 elderly interviewed it was found that (71.7%) were female, (47.9%) married / in a stable union, (85.3%) Catholic, (90.6%) did not currently work, (91.2%) retired and only (12.7%) lived accompanied. Regarding education, (65.5%) attended school, (57.0%) are literate, (43.6%) have had one to four years of study, followed by (35.5%) without any year of study. (Table1)

Table 1 - Characterization of the demographic data of the sample. Pombal, PB, Brazil, 2017

Variables	Levels	N	%
Gender	Male	87	28,3
	Female	220	71,7
Marital status	Married/Stable Union	147	47,9
	Widower	120	39,1
	Separated /Divorced	24	7,8
	Single	16	5,2
Religion	Catolic	262	85,3
	Protestant	44	14,3
	Whitout Religion	1	0,3
Currently working	Yes	29	9,4
	No	278	90,6
Retired	Yes	280	91,2
	No	27	8,8
Lives alone	Yes	40	13,0
	No	267	87,0
Lives accompanied	Yes	267	87,0
Schooled	Yes	201	65,5
	No	106	34,5
Years that attended school	Zero years	109	35,5
	1-4 years	134	43,6
	5-8 years	35	11,4
	9-11 years	14	4,6
	12 years ou +	15	4,9
Literacy	Illiterate	132	43,0
	Literate	175	57,0

Source: Research data/2017.

The assessment of the clinical profile found that (90.8%) of the elderly reported not using alcohol, (87.6%) reported not currently smoking, (23.5%) practiced some physical activity, walking was exercise most common (86.1%), performed four to seven times a week (55.6%), around 50 minutes (30.4%) per day. As for health problems, these are reported by (90.9%) of respondents, the most frequent was systemic arterial hypertension with (67.1%), loss of feces and urine with (35.5%), osteoarticular diseases with (28.0%), diabetes mellitus with (23.8%) and obesity with (22.5%) (Table 2).

Table 2 - Characterization of the Clinical Profile. Pombal, PB, Brazil, 2017

Variables	Levels	N	%
Alcoholic beverages	Yes	30	9,8
	No	277	90,2
Currently smokes	Yes	38	12,4
	No	269	87,6
Physical activity	Yes	72	23,5
	No	235	76,5
What activity do you practice	Walking	62	86,1
	Hydrogymnastics	3	4,2
	Aerobics	3	4,2
	Bike	2	2,8
	Others	2	2,8
Frequency of physical activity	1x/week	1	1,6
	2-3x/week	26	42,7
	4-7x/week	34	55,6
Practice time	30 minutes	10	14,5
	40 minutes	12	17,4
	50 minutes	21	30,4
	60 minutes	19	27,5

Variables	Levels	N	%
Health problems	Yes	279	90,9
	No	28	9,1
Evidence of health problems	Lost of feces and urine	109	35,5
	Neoplasm	7	2,3
	Heart diseases	61	19,9
	Leprosy	1	0,3
	Diabetes Mellitus	73	23,8
	Parasitic diseases	1	0,3
	Respiratory diseases	16	5,2
	Mental disorder	1	0,3
	Osteoarticular diseases	86	28,0
	Depression	10	3,3
	Obesity	69	22,5
	Kidney disease	8	2,6
	Thyroid diseases	23	7,5
	Chronic pain	1	0,3
	Arterial hypertension	206	67,1
	Dyslipidemia	65	21,2
	Previous stroke	3	1,0
	Other comorbidities	91	29,6

Source: Research data/2017.

DISCUSSION

The demographic and clinical data found in this study corroborate national and international research[9-10] that highlight a profile marked by demographic densities and predominant and determinant clinical conditions for the health of the elderly.

There was a predominance of females. Women stand out among the elderly population, given the lower mortality, a reality in many countries, especially in developed countries.[11] The feminization of old age can have both positive and negative implications for the woman herself and her family, since there is a greater social risk and, at the same time, a reorganization of the relational space as elderly women are an important link in the family support network.[12]

In addition, the rural-urban male migration, predominantly in the productive stage of young adults, arising from a rooted cultural and socioeconomic movement, being formed by a younger and female audience is one of the possible reasons for a greater number of women elderly.[13]

In view of this, several demands for care emerge from the psychological, physical and social aspects of the human being, which the interdisciplinary team of RAS must be able to act and value when constructing the therapeutic plan.

Regarding marital status, it was found that most elderly people declared to be married / in a stable relationship, a condition that expands social life, increases the family and conjugal support network, and allows the couple to age well. Elderly people with a partner have better physical and psychological well-being due to greater social and family support, and are less likely to report low quality social networks.[14]

The large representation of married elderly people can be justified as part of the culture of marriage still prevalent in northeastern Brazil, where cultural traditions and customs persist with greater strength, and are opposed to the new marriage patterns experienced by new generations.[15]

One of the factors driving this tradition may be related to religiosity, specifically to Catholicism, whose principle is based on the maintenance of the family. Historically, the predominant Catholic values in Brazil date back to the times of Portuguese colonization, where the educational process took place through evangelization, and it prevails until today.[16]

It was found in this research that a small number of elderly people still work, even retired, a fact that provides better conditions for food, health, housing and physical well-being, in addition to highlighting the need for extra income to maintain family support. As well as the search for social insertion, so diminished in this phase of life.

The National Solidarity Economy Information System (SIES) developed by the National Secretariat for Solidarity Economy (SENAES) in partnership with the Brazilian Solidarity Economy Forum recorded that, in 2012, (71.5%) of the elderly receive retirement or pension by the public health system, a fact that characterizes Brazilian families living with the elderly, since it can be seen that families living with the elderly have better socioeconomic conditions than the others.[17]

As for the aspects of living alone or accompanied, the elderly stood out who declared that they did not live alone. This finding can be justified, as this research was conducted and carried out in the interior of the Paraíba hinterland, where culturally families remain linked to the family.

The Brazilian family situation has undergone changes in cultural behavior, as well as an increase in marital separations, which contributes to the statistics of elderly people who choose to live alone.[18]

The illiteracy rate has increased as age advances, and reached percentages around (22.3%) among people aged 60 or over, in 2015.[19] In an interview with elderly people who frequent a club in the seniors, in the city of Sinop (MT), it was found that all respondents started literacy, however, most did not finish elementary school and became functional illiterates.[20] Reinforcing the direct correlation between literacy and advancing age.

It should be noted that the level of education is closely related to a better quality of life, since it provides the individual with greater autonomy and independence of activities, especially in the elderly, since knowledge about the health conditions provides the development of the empowerment of the subject, and directly affects the increase in life expectancy of this population.

In relation to health conditions, the use of tobacco in people over 18 years in Brazil corresponded to nine point

three percent, being (12.1%) among men and six point nine percent among women.[21] Smoking is as one of the main causes of preventable death in the world, its consumption stands out among the elderly and older population. The association of diseases from advancing age to smoking, and to the functional decline itself, ends up directly interfering in the quality of life of the elderly.[22]

Another aggravating factor refers to alcoholism, which in the elderly population is still a little addressed and often underdiagnosed topic. There is no clear and specific cause for the problems related to excessive alcohol consumption by this public.[23] There is a special early alcohol intake in the elderly with a family history, however, it is believed that the use of late onset is more correlated to psychological, social and physical risk factors.[24]

It is estimated that about half of the elderly are alcoholics, a trend that decreases over the years, where elderly people aged 85 and over have lower rates of alcohol consumption.[23] Alcoholism, as well as smoking, contribute to the reduction of life expectancy, as well as for worse health prognosis.

Concerning life expectancy, in a study carried out with elderly people registered at UBS, located in the South Zone of the Municipality of São Paulo, Mariana / Jabaquara, SP, with a sample of 211 women aged 60 years or over, only (19 , 9%) practiced some physical activity.[25] These data emphasize the low adherence of the elderly to physical exercises.

The practice of physical activity in the elderly is considered a potentially beneficial mechanism for the conservation of muscle mass and strength, as well as for the regulation of gait, since with age the tendency is for these parameters to decrease and make the elderly more susceptible to falls and fractures.[26]

NCDs were responsible for (68%) of a total of 38 million deaths worldwide, in 2012.22 In Brazil, in 2011, NCDs accounted for (68.3%) of the causes of deaths, with emphasis on cardiovascular diseases with (30.4%), followed by neoplasms with (16.4%), chronic respiratory diseases with six point zero percent and diabetes with five point three percent.[27]

Among the NCDs common to aging, Systemic Arterial Hypertension (SAH) and Diabetes Mellitus (DM) are considered the main causes of cardiac, cerebrovascular and renal complications,[6] and associated with these are overweight and obesity that are related to an increased risk of cognitive decline, regardless of other morbidities.[28,9.]

A study carried out in northwest Ethiopia, with a total of 67,397 people, found that 1,160 people had at least one chronic non-communicable disease. Heart disease and hypertension accounted for (32.2%) and (31.9%), respectively of the total disease burden, followed by asthma with (27.7%), diabetes mellitus with four point nine percent and cases of cancer with three point two percent. Also noting that factors such as age, living in an urban area, family insecurity and high income were positively associated with the reported history of NCDs, while low income, moderate alcohol consumption, agricultural occupation and work-related physical activities were inversely associated.[10]

Such data are consistent with the findings of this research, in which the highest prevalence of CNCD in the elderly corresponded to SAH, DM, obesity, as well as osteoarticular diseases and loss of feces and urine, among others. An interesting data related to this sample concerns the loss of feces and urine, which was in second place among all the diseases elucidated here.

In a survey carried out in the municipality of Pelotas, RS, with 132 elderly women, the prevalence found for urine loss was (40.91%).[29] However, in a study conducted in the city of João Pessoa, PB, with a sample of 322 elderly, the prevalence of Urinary (UI) and Fecal (IF) incontinence was (10.25%) and zero point thirty-one percent, respectively. However, (37.27%) of the elderly had both UI and IF, double incontinence.[30]

The presence of sphincter problems in the elderly predisposes to conditions of social isolation, shame, loneliness, restriction to public environments that weaken and compromise the quality of life, and contributes to the worsening of the functional, physical and mental decline, which denotes the need for acting more oriented to guidance and encouragement of exercises that value greater sphincter control and strengthening of the pelvic muscles, since this would allow greater autonomy and independence in their daily activities of daily living.[30]

Notoriously, it is essential to carry out measures aimed at promoting health and preventing damage and injuries, as well as maintaining and rehabilitating health, according to the principles of equity and integrality of care, especially with regard to Primary Health Care, since this is the primary access door to serving the elderly.

CONCLUSION

The characteristics of the epidemiological profile of the elderly point to the need for further discussions and investigations about aging and its determinants, since it is directly associated with the emergence of chronic and debilitating diseases, which leads to physical and emotional dysfunctions.

The use of preventive measures and health promotion strategies through educational actions regarding morbidities, especially with regard to Primary Health Care, would enable the realization of early interventions regarding health problems and damages, and the consequent losses to quality and health. life expectancy of the elderly population.

The effective development of these strategies would be of fundamental importance and would expand the possibilities of care and management of the health needs of the elderly, with improved quality of life, maintenance and recovery of autonomy and independence, all with a view to the biopsychosociocultural well-being of the sixties.

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