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QUALITY OF LIFE ASSESSMENT IN ELDERLY FROM THE COMMUNITY

Avaliação da qualidade de vida em idosos da comunidade

Evaluación de la calidad de vida de ancianos de la comunidad

Beatriz Campos de Oliveira
University of Rio Verde (*Universidade de Rio Verde - UniRV*) - Aparecida de Goiânia (GO) - Brazil

Naiane Moreira Barbosa
University of Rio Verde (*Universidade de Rio Verde - UniRV*) - Aparecida de Goiânia (GO) - Brazil

Marina Saint'Clair Mattioda de Lima
University of Rio Verde (*Universidade de Rio Verde - UniRV*) - Aparecida de Goiânia (GO) - Brazil

Heloísa Silva Guerra
University of Rio Verde (*Universidade de Rio Verde - UniRV*) - Aparecida de Goiânia (GO) - Brazil
State University of Goiás (*Universidade Estadual de Goiás - UEG*) - Ceres (GO) - Brazil

Carlos Magno Neves
Federal University of Goiás (*Universidade Federal de Goiás - UFG*) - Goiânia (GO) - Brazil

Juliana Boaventura Avelar
Federal University of Goiás (*Universidade Federal de Goiás - UFG*) - Goiânia (GO) - Brazil

ABSTRACT

Objective: To assess the quality of life of the elderly in the community linked to a family health unit. **Methods**: Descriptive, cross-sectional study with 98 elderly people linked to a basic health unit (BHU) in a municipality of the state of Goiás, Brazil, between February and April 2016. The data were collected through a structured interview using an instrument addressing the sociodemographic aspects and morbidities reported by the elderly, and the Flanagan Quality of Life Scale, which conceptualizes the quality of life from five domains: physical and material well-being; relations with other people; social, community, and civic activities; personal development and fulfillment; and recreation. For data analysis, the study applied descriptive statistics, univariate analysis, and multiple logistic regression; Chi-square test and Fisher's exact test were used to compare proportions. **Results:** The majority of the elderly people were female 59 (60.2%), with a mean age of 69 years (SD ± 6.8), 40 (40.8%) were married and 56 (57.1%) had completed middle school. Among the participants, 52 (53.1%) were sedentary and 77 (87.8%) reported at least one medical condition. The mean Flanagan Scale total score was 86.3 (± 10) points, reflecting a high quality of life. Practicing physical activity (p=0.019) and having some level of education (p=0.012) showed a tendency for a better perception of quality of life. **Conclusion:** The elderly's quality of life was considered high according to the Flanagan Quality of Life Scale, with higher satisfaction rates in the domain "listening to music, watching TV or going to the movies, reading or other entertainments."

Descriptors: Elderly; Quality of Life; Public Health; Primary Health Care.

RESUMO

Objetivo: *Avaliar a qualidade de vida de idosos da comunidade vinculados a uma unidade de saúde da família.* ***Métodos:*** *Estudo descritivo e transversal, realizado com 98 idosos vinculados a uma unidade básica de saúde (UBS) de um município de Goiás, Brasil, entre fevereiro e abril de 2016. Os dados foram coletados por meio de entrevista estruturada utilizando um instrumento sobre os aspectos sóciodemográfico e morbidades referidas pelos idosos, e a Escala de Qualidade de Vida de Flanagan, que conceitualiza a qualidade de vida a partir de cinco dimensões: bem-estar físico e material; relações com outras pessoas; atividades sociais, comunitárias e cívicas; desenvolvimento pessoal e realização; e recreação. Para a análise dos dados empregou-se a estatística descritiva, univariada, regressão logística múltipla, teste de Qui-Quadrado e exato de Fisher para comparar proporções.* ***Resultados:*** *A maioria dos idosos era do sexo feminino 59 (60,2%), com média de idade de 69 anos (DP±6,8), 40 (40,8%) casados e 56 (57,1%) haviam cursado ensino fundamental completo. Dentre os participantes, 52 (53,1%) eram sedentários e 77 (87,8%) referiram pelo menos um problema de saúde. A média de pontuação total na escala de Flanagan foi de 86,3 (±10) pontos, refletindo alta qualidade de vida. Praticar atividade física (p=0,019) e possuir algum grau de instrução (p=0,012) apresentou tendência a melhor percepção da qualidade de vida.* ***Conclusão:*** *A qualidade de vida dos idosos foi considerada alta de acordo com a Escala de Qualidade de Vida de Flanagan, com maiores índices de satisfação no domínio "ouvir música, assistir TV ou cinema, leitura ou outros entretenimentos".*

Descritores: *Idoso; Qualidade de Vida; Saúde Pública; Atenção Primária à Saúde.*

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RESUMEN

Objetivo: *Evaluar la calidad de vida de ancianos de la comunidad que tienen vínculo con una unidad de salud de la familia.* ***Métodos:*** *Estudio descriptivo y transversal realizado con 98 ancianos con vínculo con una unidad básica de salud (UBS) de un municipio de Goiás, Brasil, entre febrero y abril de 2016. Los datos fueron recogidos a través de entrevista estructurada con un instrumento sobre los aspectos sociodemográficos y morbidades relatadas por los ancianos y la Escala de Calidad de Vida de Flanagan la cual conceptualiza la calidad de vida a partir de cinco dimensiones: bienestar físico y material; relaciones con otras personas; actividades sociales, de las comunidades y cívicas; desarrollo personal y realización; y recreación. Para el análisis de los datos se usó la estadística descriptiva, univariada, la regresión logística múltiple, la prueba de Chi-cuadrado y el Test exacto de Fisher para la comparación de las proporciones.* ***Resultados:*** *La mayoría de los ancianos era del sexo femenino 59 (60,2%) con media de edad de 69 años (DP±6,8), 40 (40,8%) eran casados y 56 (57,1%) tenían la educación primaria completa. De entre los participantes, 52 (53,1%) eran sedentarios y 77 (87,8%) relataron al menos uno problema de salud. La media de la puntuación total de la escala de Flanagan fue de 86,3 (±10) puntos lo que refleja una calidad de vida elevada. La práctica de actividad física (p=0,019) y el hecho de tener algún grado de instrucción (p=0,012) llevó a una tendencia de mejor percepción de calidad de vida.* ***Conclusión:*** *La calidad de vida de los ancianos ha sido considerada elevada según la Escala de Calidad de Vida de Flanagan con índices mayores de satisfacción para el dominio "escuchar música, ver la TV o cine, lectura u otros entretenimientos".*

Descriptores: *Anciano; Calidad de Vida; Salud Pública; Atención Primaria de Salud.*

INTRODUCTION

Population aging is a worldwide phenomenon, faced by both the developed and developing countries. In the case of the latter, aging has occurred more rapidly, becoming one of the greatest challenges of contemporary public health[1]. Brazil is already regarded an aging nation, with projections of 57 million elderly people in 2040[2]. With the increasing rise in life expectancy, it has been created a demand for studies and analyses aimed at obtaining data for optimization of the public policies and quality of life for the elderly population[3].

The quality of life (QOL) assessment is fundamental and should be considered an integral part of the evaluation of the health of the elderly for addressing aspects that go unnoticed during the clinical evaluation in health services. Through the identification of different aspects of quality of life, data are obtained to support the definition of an appropriate strategy to help the elderly get adapted to the physical, social and emotional losses that occur in old age[4]. These data are important as population aging reveals the need for an assistance focused on the health promotion of this population group, with the active and healthy aging as the central objective[5].

The concept of quality of life encompasses the multidisciplinarity of knowledge by comprising distinct forms of science and the popular knowledge, in addition to concepts that permeate the lives of people as a whole. It involves innumerable elements of the daily life of human beings: from the subjective perception of and expectation about life up to issues such as coping with diseases and illnesses[6].

Despite the diversity featured by the concept of quality of life, because of its multifactorial character and of multidisciplinary use, there is consensus as to the presence of three basic aspects: subjectivity, multidimensionality and bipolarity[7].

In the QoL assessment, the adoption of multiple criteria of biological, psychological and socio-structural nature is mandatory, since several elements are pointed as indicators of well-being in the old age: longevity, biological health, mental health, satisfaction, cognitive control, social competence, productivity, activity, cognitive efficacy, social status, income, continuity of family and occupational roles, and continuity of informal relations with friends[7].

Several instruments have been used to assess quality of life, being generally divided into two groups: generic and specific. Among the generic instruments, which assess different aspects of the quality of life of the individual, stand the WHOQOL-100, developed by the World Health Organization (WHO), the Nottinghan Health Profile (NHP), the Medical Outcomes Short Form Health Survey (SF-36), the AQUAREL, and the Flanagan Scale. Among the specific ones, aimed at evaluating aspects of quality of life directly affected by diseases, stand the Diabetes Care Profile (DCP), Parkinson's Disease Quality of Life (PDQL), and the Fibromialgic Impact Questionnaire (FIQ), among others[8].

Considering the multidimensionality, the Flanagan Quality of Life Scale (QOLS)[9)] has been validated in Brazil with 15 items, representing five conceptual domains: physical and material well-being; relations with other people; social and civic activities; personal development and fulfillment; and recreation. The item on well-being refers to good physical disposition, comfort and material security; the one on relations comprises the affective ties, conditioned by various reciprocal attitudes; the activity encompasses behaviors emitted as a response when developing recreational activities, such as senior citizen clubs, or when exercising rather political actions, such as retirement associations; personal development consists of self-acceptance, positive relations with others, autonomy, sense of mastery and goal-seeking; and the item on recreation includes the activities of individual and social entertainment[10].

The use of Flanagan's scale for QOL assessment in the old age becomes important, since it presents and clarifies several aspects of the life of the elderly, especially those of intersubjective nature and of greater probability of occurrence in the old age, such as cases of diseases, loss of occupational roles and emotional losses.

In view of this context, the objective of this study was to evaluate the quality of life of the elderly of the community linked to a family health unit.

METHODS

This was a descriptive and cross-sectional study, carried out between February and April 2016. The sample, composed by convenience, included 98 elderly people linked to the Santa Luzia Basic Health Unit, in the municipality of Aparecida de Goiânia, Goiás, Brazil.

In order to select the participants, the following inclusion criteria were adopted: elderly people aged 60 years or older, regardless of sex, who were able to express themselves verbally. Those presenting some kind of cognitive deficit and those who had no interest in contributing to the study were not included in the sample.

Data collection took place at the very basic health unit (BHU), at the moment when the elderly patients attended for consultations or other procedures. The elderly who accepted to participate in the study were given a thorough reading of the Informed Consent (ICF), and later, the instruments were applied under the supervision of the researchers.

The structured interview, by means of the printed instruments, was conducted in a private room, having one of the three evaluators, previously trained, as mediator. The evaluator read the question, as well as the response options for the elderly, and waited for him to point out the alternative that suited them best.

Two instruments were used to operationalize the data collection, the first one related to sociodemographic data and morbidities reported by the elderly, and the second one on the quality of life. The Flanagan Scale was chosen for being an instrument of easy application, which conceptualizes the quality of life from five dimensions: physical and material well-being; relations with other people; social, community and civic activities; personal development and fulfilment; and recreation. These dimensions are measured through fifteen items, in which the respondent has seven response options, ranging from "very unsatisfied" (score 1) to "very satisfied" (score 7). The maximum score reached is 105 points and the minimum score is 15 points, which respectively reflect the highest and lowest quality of life[11].

This scale, rendered into Portuguese, has its reliability calculated, reflecting Cronbach's alpha coefficient of 0.90 and the split-half test (data on even-numbered items X odd-numbered items) with a score of 0.86[9]. The construct validity was reached by the author when inductively constructing the instrument from the results of the factor analysis performed[12].

Descriptive statistics was applied, with presentation of the median, mean and standard deviation for continuous variables (sociodemographic data), and percentage and absolute values for categorical variables (quality of life dimensions). In the QOLS analysis, the coefficient of variation was calculated and, the larger the range of values for the coefficient of variation, the greater the difference of opinion regarding the elderly's satisfaction in the item evaluated.

Univariate analysis was performed using the chi-square test, or Fisher's exact test, for comparing proportions, and Odds ratio as a measure of effect to verify the existence of an association between the elderly's sociodemographic characteristics and the high satisfaction score. The variables that obtained $p<0.10$ in the univariate analysis were submitted to multiple logistic regression and adjusted for sex and age, considering a significance level of 5%. The Statistical Package for the Social Sciences, version 20.0, was used for data analysis.

In compliance with Resolution no. 466/12 of the National Health Council[13], the research was submitted to the Research Ethics Committee of Rio Verde Higher Education Foundation - FESURV - University of Rio Verde, with subsequent approval under Opinion no. 1 121 012.

RESULTS

A total of 98 elderly people enrolled in and served by a BHU of the municipal public health network of Aparecida de Goiânia participated in the study, of which 59 (60.2%) were female and 39 (39.8%) were male. The mean age was 69 years (SD ± 6.8), with a minimum age of 60 and maximum of 88 years. The predominant age group was between 60 and 69 years, which corresponded to 58 (59.2%) elderly individuals (Table I). The sample participating in the study featured the following characteristics: 40 (40.8%) were married, 56 (57.1%) had completed elementary school, 76 (77.6%) lived with someone, and 85 (86.7%) had income of 1 to 3 minimum wages.

Table I - Sociodemographic profile of the elderly linked to a basic family health unit. Aparecida de Goiânia, Goiás, Brasil, 2016.

Characterization	n	%
Sex		
Male	39	39.8
Female	59	60.2
Age		
60 to 69 years	58	59.2
70 to 79 years	32	32.7
80 to 89 years	8	8.2
Civil status		
Single	22	22.4
Married	40	40.8
Widower	20	20.4
Divorced	16	16.3
Education		
None	23	23.5
Incomplete elementary school	2	2.0
Complete elementary school	56	57.1
Complete High School	12	12.2
Complete Higher Education	5	5.1
Occupation		
Retired	75	76.5
Retired but carrying out an informal activity	3	3.1
Housekeeper	8	8.2
Others*	11	11.2
Income**		
Less than one minimum wage	7	7.1
One to three minimum wages	85	86.7
Above four minimum wages	4	4.1
Did not answer	2	2.0
Housing (type)		
Leased	6	6.1
Own	78	79.6
Belongs to relatives	7	7.1
Others	7	7.1
Dwelling (with whom resides)		
Another person	76	77.6%
Alone	22	22.4
Total	98	100

* Security guard, trader, seamstress, and others.
**Value of minimum wage in the year of research R$ 880.00.

Regarding health and life habits, 86 (87.8%) of the elderly reported at least one health issue; 77 (78.6%) were non-alcoholic, 74 (75.5%) were non-smokers and 52 (53.1%) were sedentary. With regard to the health problems reported, 59 (60.2%) reported hypertension, 26 (26.5%) diabetes mellitus, and 34 (34.7%) other conditions, such as depression, musculoskeletal issues, asthma/bronchitis, cancer, dyslipidemia and insomnia. The mean of the total score obtained by the elderly on the Flanagan scale was 86.3 (± 10), ranging from 53 to 105 points.

Table II presents the satisfaction score of the elderly in relation to several aspects of life by means of the QOLS. The highest reported satisfaction was related to the item "listening to music, watching TV or cinema, reading or other entertainments", with a mean score of 6.5, and relatively low standard deviation intervals and coefficient of variation, which indicates little divergence in the elderly's opinion.

Other aspects of life that obtained high satisfaction scores, with an average of 6.1 or higher, were the items that evaluated the socialization, helping and supporting others voluntarily, forming a family - having and raising children, relations with relatives and sharing interests, activities and opinions with close friends (Table II).

Table II - Satisfaction score according to the Flanagan Quality of Life Scale referred by elderly people linked to a basic family health unit. Aparecida de Goiânia, Goiás, Brasil, 2016.

Satisfaction	Median	Average	Standard deviation	Coefficient of variation
Material well-being: home, food, financial status	6.0	5.9	1.4	1.8
Health: physically well and vigorous	6.0	5.3	1.6	2.7
Relations with parents, siblings and other relatives: communication, visit and help	7.0	6.3	1.5	2.2
Constituting a family: having and raising children	7.0	6.3	1.4	2.0
Intimate relations with spouse, boyfriend or significant other	4.0	5.0	1.9	3.6
Close friends: sharing interests, activities and opinions	7.0	6.1	1.4	2.0
Voluntarily, helping and supporting other people	7.0	6.2	1.4	1.9
Participation in associations and activities of public interest	5.0	5.1	1.5	2.4
Learning: attending other courses for general knowledge	6.0	5.3	1.5	2.3
Self-awareness: recognizing your potentials and limitations	5.0	4.9	1.8	3.3
Work (employment or at home): interesting, rewarding activity that is worth it	6.5	5.7	1.8	3.1
Creative communication	6.0	5.7	1.4	2.0
Participation in active recreation	6.0	5.5	1.6	2.6
Listening to music, watching TV or cinema, reading or other entertainments	7.0	6.5	0.9	0.9
Socialization: "making friends"	7.0	6.4	1.1	1.1

Table III shows the association between the satisfaction score and the characteristics of the elderly. The general satisfaction score for the elderly was 5.7, with a standard deviation of 0.7 and variance of 0.5, with a minimum of 3.5 and a maximum of 7.0. The univariate analysis showed that performing physical exercise (p=0.019) and having some level of education (p=0.012) seem to be associated with a better perception of the quality of life among the elderly.

Table III - Satisfaction score of elderly people linked to a basic family health unit in relation to the Flanagan Quality of Life Scale and sociodemographic and clinical characteristics. Aparecida de Goiânia, Goiás, Brazil, 2016.

Variables	Satisfaction score 6.0 or more n/total	OR (95% CI)	p
Sex			
Male	19/39	1.8 (0.8-4.2)	0.142
Female	20/59		
Age			
Up to 69 years	25/58	1.4 (0.6-3.2)	0.421
70 or more years	14/40		
Lives alone			
Yes	10/22	1.3 (0.5-3.5)	0.538
No	29/76		
Married / In a stable union			
Yes	19/40	1.7 (0.8-3.9)	0.196
No	20/58		
Income			
Up to a minimum wage	2/7	0.6 (0.1-3.2)	0.700*
Above one minimum wage	36/89		
Home			
Own	34/78	2.3 (0.8-7.0)	0.130
Not own	5/20		
Education			
Has some level of education	35/75	4.2 (1.3-13.4)	0.012
No education	4/23		
Performs physical activity			
Yes	24/46	2.7 (1.2-6.2)	0.019
No	15/52		
Health issues			
Yes	36/86	2.2 (0.6-8.5)	0.353*
No	3/12		

*Fisher's exact test; OR: Odds Ratio

However, after adjusting these two variables for sex and age, as shown in Table IV, there were no independent associations between the exposure variables and the best satisfaction score. Although not significant, the level of education and the practice of physical activity present tendency to a better perception of the quality of life, given that $p<0.10$.

Table IV - Adjustment of the significant variables sex, age, level of education and performing physical activity, in univariate analysis. Aparecida de Goiânia, Goiás, Brazil, 2016.

Variables	Unadjusted value			Adjusted value		
	OR	95% CI	p	OR	95% CI	p
Male	1.8	0.8-4.2	0.142	1.7	0.7-4.3	0.228
Age≤69 years	1.4	0.6-3.2	0.421	1.2	0.5-3.0	0.715
Some level of education	4.2	1.3-13.4	0.012	2.9	0.9-10.0	0.089
Performs physical activity	2.7	1.2-6.2	0.019	2.2	0.9-5.2	0.084

OR: Odds Ratio; CI: Confidence Interval

In the quality of life of the elderly assessment scale (Table V), Cronbach's alpha of 0.74 was obtained, which corresponds to the acceptable reliability standard.

Table V - Quality of life assessment by the Flanagan Quality of Life Scale of the elderly linked to a basic family health unit according to the satisfaction score category. Aparecida de Goiânia, Goiás, Brazil, 2016.

Aspects of life	Satisfaction score			
	1 to 2 n (%)	3 to 4 n (%)	5 to 6 n (%)	7 n (%)
Material well-being: home, food, financial status	5 (5.1%)	8 (8.1%)	42 (42.8%)	43 (43.9%)
Health: physically well and vigorous	8 (8.1%)	16 (16.3)	44 (44.9)	30 (30.6)
Relations with parents, siblings and other relatives: communication, visit and help	5 (5.1%)	6 (6.1%)	23 (23.4%)	64 (65.3%)
Constituting a family: having and raising children	4 (4.1%)	6 (6.1%)	19 (19.4%)	69 (70.4%)
Intimate relations with spouse, boyfriend or significant other	10 (10.2%)	41 (41.8%)	13 (13.2%)	34 (34.7%)
Close friends: sharing interests, activities and opinions	6 (6.1%)	5 (5.1%)	30 (30.6%)	57 (58.2%)
Voluntarily, helping and supporting other people	4 (4.0%)	9 (9.2%)	21 (21.4%)	64 (65.3%)
Participation in associations and activities of public interest	6 (6.1%)	40 (40.8%)	27 (27.5%)	25 (25.5%)
Learning: attending other courses for general knowledge	3 (3.0%)	39 (39.8%)	24 (24.5%)	32 (32.7%)
Self-awareness: recognizing your potentials and limitations	11 (11.2%)	31 (31.6%)	28 (18.5%)	28 (28.6%)
Work (employment or at home): interesting, rewarding activity that is worth it	9 (9.2%)	13 (13.2%)	27 (27.5%)	49 (50.0%)
Creative communication	2 (2.0%)	31 (31.6%)	19 (19.4%)	46 (46.9%)
Participation in active recreation	7 (7.1%)	26 (26.5%)	29 (29.6%)	36 (36.7%)
Listening to music, watching TV or cinema, reading or other entertainments	-	9 (9.2%)	23 (23.4%)	66 (67.3%)
Socialization: "making friends"	-	13 (13.3%)	16 (16.3%)	69 (70.4%)

The items that presented the highest tendency to satisfaction (values between 5 and 7 points) among the elderly were "listening to music, watching TV or cinema, reading or other entertainment", with 89 (90.7%) responses; the item "constituting a family", with 88 (89.8%); and the item "close friends: sharing interests, activities and opinions", with 87 (88.8%). The only item with a tendency to dissatisfaction (values between 1 and 4 points) was "intimate relations with spouse, boyfriend or other relevant person", with 51 (52%) responses.

DISCUSSION

The results of the present study point out some characteristics of the elderly's profile that corroborate what is observed in the literature, with a predominance of the female sex, married, retired, with low schooling and income[14-16].

A significant proportion of the elderly in this study reported being sedentary, although much of the sample was neither alcoholic nor smoker. A majority of them reported at least one health issue, with hypertension, diabetes mellitus and vision changes as the most commonly reported. Indeed, the presence of many diseases is commonly observed among the elderly, especially the chronic-degenerative ones. Although the aging process is not necessarily associated with diseases and disabilities, elderly individuals end up presenting more health conditions due to the longer life expectancy[17].

In the current study, most of the elderly reported being satisfied with the quality of life assessed by the QOLS. The mean obtained in the instrument was 86.3 points, corroborating the findings of other studies[18,19].

The highest satisfaction score reported by the elderly participants in the present study refers to the domain that deals with "listening to music, watching TV or cinema, reading or other entertainments". The participation of the individual in recreational activities provides better relations between them and other people, and the world as well, favoring interpersonal relations and environmental interaction, contributing to a better quality of life[20].

Daily recreation is an important factor that leads to improvements in the physical, spiritual and social aspects for the elderly, and the main activities performed by them are: watching television, walking, playing cards, listening to music and doing household activities. Thus, the good evaluation presented in this item suggests that the sample of this study also prioritizes recreation in its daily life, and that such entertainments directly contribute to the well-being and quality of life of this population[21].

The elderly in this study also pointed out as important for a good quality of life the items "socialization, helping and supporting other people voluntarily", "constituting family", "relations with family members" and "sharing interests with close friends". These findings agree in part with a Brazilian study[19], in which the authors evaluated 688 individuals, aged 18 to 81 years, using the QOLS, and found that "constituting family" and "relations with relatives" were the aspects of greatest satisfaction among the participants. Regardless of the individual's origin, culture or health status, the formation of a family is an important aspect[22].

In the present study, performing physical activity and having some level of education was associated with a better perception of the quality of life among the elderly, corroborating another study, in which physical activity and schooling had a positive influence on the quality of life of the elderly evaluated[23]. Older people with higher levels of education have better access to various services, including the health services, and to activities that stimulate cognition and social participation, contributing to better QoL rates[18].

The participation of the elderly in aquatic exercise programs, aerobic training, in association with strength and coordination exercises, is related to higher quality of life satisfaction scores, thus evidencing the influence exerted by the practice of physical activity on the quality of life of the elderly[24].

Elderly people who participate in physical activity programs (walking, muscular strengthening, resistance, flexibility and balance) present a better quality of life than elderly people who do not participate in such activities[25].

As to the education level in the elderly population, it is important to highlight the fact that schooling is associated with cognition, since a low education level is directly related to diffusion or cognitive loss[26].

Schooling is one of the main aspects related to quality of life in different population groups. Low schooling implies difficulty in accessing health education and, consequently, the adoption of healthy habits of life is compromised, in addition to undermining the understanding of the guidelines made by health professionals, which could collaborate for a better quality of health[27].

Regarding the negative aspects evidenced by this study, it was observed that the only domain showing a tendency to dissatisfaction in the QOLS relates to the issues of "intimate relations with spouse, boyfriend or other relevant person." A majority of the elderly participants declared themselves to be single, widowed, or divorced; which does not clarify as to the existence or not of a partner with whom they can relate intimately.

Aging is marked by several changes, both physical, psychological and emotional, and it might be considered, from a biological point of view, a stage of morphofunctional regression that manifests itself in different ways among the individuals. The fact that an organism grows old does not imply that the elderly have to lose their feelings and sensations. At this stage, it is possible for the individual to enjoy an active, healthy and happy life, and sexuality can be experienced to the end[28]. However, the old age is still permeated by stereotypes, being associated with human and biological decay, disseminating a distorted image of the possibilities that the elderly still have.

The findings of the present study suggest that the elderly people who were evaluated are not satisfied with intimate relations, either because of the non-existence of a partner, which would lead them to solitude, or because of the belief that it is not possible to experience sexuality in this stage of life. One factor that may help to understand the latter possibility is that the education of the current elderly population was repressive, and there was almost no dialogue between parents and children, nor space to talk about sexuality, which makes them feel uncomfortable in giving opinions and talking about it, thus remaining with doubts and misinformation[29].

The main health promotion interventions pointed out in the literature, concerning the elderly, consider important aspects of their context, such as health status, disease, functionality and motivation[30]. Studies approaching the quality of life are

important, since they can contribute to a better orientation of the health professionals' actions directed at this public, serving as allies in the planning and conduction of the work of health teams, and enabling the targeting of intervention strategies intended to the overall improvement of their lives.

Some limitations were found in the accomplishment of the present study, such as: the reduced number of the sample, the cross-sectional design, which makes it impossible to establish causal relations, and the scarcity of publications addressing the Flanagan scale.

It is suggested that further studies seeking to evaluate the quality of life in the old age be conducted, since they enable a comprehensive analysis of the individual, encompassing several aspects related to their values, goals and expectations. The findings can collaborate in the improvement of the care provided, the health status and, consequently, the quality of life of the elderly.

CONCLUSION

In a general context, it can be affirmed that the quality of life of the elderly people linked to a basic health unit of the municipality of Aparecida de Goiânia is considered high, according to the Flanagan Quality of Life Scale. The highest satisfaction score was reported in relation to the item "listening to music, watching TV or cinema, reading or other entertainments", and the one that demonstrated the greatest dissatisfaction referred to "intimate relations with spouse, boyfriend or other relevant person".

CONFLICTS OF INTEREST

The authors of this paper have no conflicts of interest of any nature to declare.

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First author's address:
Beatriz Campos de Oliveira
Universidade de Rio Verde - UniRV
Campus Aparecida
Avenida das Palmeiras, chácaras 26 e 27
Bairro: Jardim dos Buritis
CEP: 74923-590 - Aparecida de Goiânia - GO - Brasil
E-mail: biacampos029@gmail.com

Mailing address:
Heloísa Guerra
Avenida das Palmeiras, chácaras 26 e 27
Bairro: Jardim dos Buritis
CEP: 74923-590 - Aparecida de Goiânia - GO - Brasil
E-mail: heloisasguerra@gmail.com