Revista Brasileira de Enfermagem
REBEn
SUPPLEMENTARY EDITION 3
GERONTOLOGICAL NURSING

ORIGINAL ARTICLE

# Participation in the coexistence center for elderly: repercussions and challenges

*A participação no centro de convivência para idosos: repercussões e desafios*

*La participación en el centro de convivencia para ancianos: repercusiones y desafíos*

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**How to cite this article:**
GAS Scolari, Derhun FM, Rissardo LK, Baldissera VDA, Radovanovic CAT, Carreira, L. Participation in the coexistence center for elderly: repercussions and challenges. Rev Bras Enferm. 2020;73(Suppl 3):e20190226. doi: http://dx.doi.org/10.1590/0034-7167-2019-0226

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**Submission:** 06-11-2019 **Approval:** 11-11-2019

## ABSTRACT

**Objective**: To analyze the repercussions on the life of the elderly after joining a coexistence center and the existing challenges from the perspective of the participants and their families. **Methods:** Qualitative research conducted with 16 elderly from a coexistence center and 14 family members. Data were collected through individual interviews and subjected to content analysis. **Results:** Two thematic categories were identified: "Before and after: changes in the life of the elderly after joining the coexistence center" and "Aspects needed to improve care in the coexistence center". **Final Considerations:** The benefits of older people's participation in the service are evidenced by changes in lifestyle and interrelationships. However, there is a need to expand assistance in these institutions, with a multidisciplinary team trained in gerontogeriatric care, as well as to consider the importance of nursing as a science of care and insert it in this service.
**Descriptors:** Aged; Frail Elderly; Health Services for the Aged; Geriatric Nursing; Social Vulnerability.

## RESUMO

**Objetivo**: Analisar as repercussões ocorridas na vida de idosos a partir do ingresso em um centro de convivência e os desafios existentes na ótica dos participantes e seus familiares. **Métodos:** Pesquisa qualitativa realizada com 16 idosos de um centro de convivência e 14 familiares destes. Os dados foram coletados por meio de entrevistas individuais e submetidas à análise de conteúdo. **Resultados:** Identificaram-se duas categorias temáticas: "O antes e o depois: mudanças na vida do idoso após o ingresso no centro de convivência" e "Aspectos necessários para a melhoria do atendimento no centro de convivência". **Considerações finais:** Os benefícios da participação do idoso no serviço são evidenciados por mudanças nos hábitos de vida e nos inter-relacionamentos. Contudo, há a necessidade de ampliar a assistência nessas instituições, com equipe multidisciplinar capacitada em gerontogeriatria, bem como considerar a importância da enfermagem como ciência do cuidado e inseri-la nesse serviço.
**Descritores:** Idoso; Idoso Fragilizado; Serviços de Saúde para Idosos; Enfermagem Geriátrica; Vulnerabilidade Social.

## RESUMEN

**Objetivo**: Analizar las repercusiones ocurridas en la vida de ancianos a partir del ingreso en un centro de convivencia y los desafíos existentes en la óptica de los participantes y sus familiares. **Métodos:** Investigación cualitativa realizada con 16 ancianos de un centro de convivencia y 14 familiares de estos. Los datos han sido recogidos por medio de entrevistas individuales y sometidas al análisis de contenido. **Resultados:** Se identificaron dos categorías temáticas: "El antes y el después: cambios en la vida del anciano después del ingreso en el centro de convivencia" y "Aspectos necesarios para la mejoría de la atención en el centro de convivencia". **Consideraciones Finales:** Los beneficios de la participación del anciano en el servicio son evidenciados por cambios en los hábitos de vida y en las interrelaciones. Sin embargo, hay la necesidad de ampliar la asistencia en estas instituciones, con equipo multidisciplinar capacitado en gerontogeriatría, bien como, considerar la importancia de la enfermería, como ciencia del cuidado, y añadirla en esto servicio.
**Descriptores:** Anciano; Anciano Frágil; Servicios de Salud para Ancianos; Enfermería Geriátrica; Vulnerabilidad Social.

## INTRODUCTION

In recent years, there has been a considerable improvement in life expectancy at birth and a fall in fertility rates, which has led to an increase in the number of elderly individuals. Such events, on the one hand, are considered an achievement for society, but on the other, they bring challenges related to the capacity of social and health systems to meet the biopsychosocial needs of the elderly population, especially due to the increase in functional limitations in the older age groups[1].

A study with 23,815 elderly Brazilians found that 30% have difficulty performing one or more daily life activities. Of the elderly with functional limitations, 81.2% reported receiving or needing help to perform activities, and of these, 5.7% received no help; 81.8% received only informal help; 5.8% received only paid help and, 6.8% received mixed aid. Among the elderly who reported receiving help, 62% received it from an unemployed family member living in the same household; 35.8% of an unemployed family member living in another household; 4.9% of family members or other unemployed person; 3.4% of hired caregivers; and 10.3% of an employed family member or a domestic worker[2].

What is worrisome in this context is that the availability of informal care, which most older people benefit from and relies on[2], tends to decrease further soon, due to fewer family conformations. membership and increasing participation of women in the labor market[3]. This will possibly increase in the number of older people caring for other older people, often without adequate physical and cognitive conditions[4], placing them in a more vulnerable situation[5] .

It is understood that care for the elderly provided only by the family is not sustainable, and there must be a relationship between families, coexistence and state to share this care[6]. In this sense, Brazil, through the Department of Health (Ministério da Saúde), launched the guide "Technical guidelines for the implementation of a care line for comprehensive health care for the elderly in the Unified Health System", which points out the centers of coexistence, service Social Assistance, as alternative care for people over 60 years old who have some degree of dependence, in which family and service are co-responsible for the care given to the elderly[7-8].

Such services are designed for daytime stay of older people who continue to live in their homes and have their families as their reference unit[7-8]. The purpose of the coexistence center is to offer multidisciplinary care to elderly individuals, to social integration and the promotion and preservation of autonomy and independence, through integration into sociocultural, recreational, work and citizenship education activities[9].

Although the literature has benefits on the participation of the elderly in social centers[9-12], little is known about the aspects that permeate the repercussions on the elderly's life after they are admitted to these institutions. Expanding the knowledge produced about the real repercussions of such services on the lives of the elderly and their families in the light of the conceptual basis of the World Report on Ageing and Health is an alternative to boost actions and policies in the area health of the elderly, in order to meet the demands of this population. From this, one asks: What changes occurred in the lives of the elderly after they were admitted to a coexistence center?

## OBJECTIVE

To analyze the repercussions on the life of the elderly after joining a coexistence center and the existing challenges from the perspective of the participants and their families.

## METHODS

### Ethical aspects

The research project was approved by the Ethics Committee of the State University of Maringá - PR. All participants were informed about the research, and after verbal acceptance, they read and signed the Informed Consent Form (ICF). To ensure the anonymity and confidentiality of the information, we identified the participants with the letter "E" (referring to the term "Elderly") or "F" (referring to the term "Family"), followed by Arabic numerals, that corresponded to the order of the interviews.

### Study type and conceptual basis

This is a descriptive, exploratory and qualitative study, which used, as a conceptual basis, the World Report on Ageing and Health and, as an analytical framework, the content analysis in the thematic modality. The use of the conceptual aspects of the World Report on Ageing and Health occurred due to the foundation of its recommendations, which point to the need for profound changes in the way of developing policies and providing health services to the elderly population[6].

### Methodological procedures

#### *Study scenario*

We developed this study with elderly and family members who attend a coexistence center in a municipality in the northwest of the state of Paraná, Brazil. The municipality has 423,666 inhabitants, of which 54,190,000 are elderly, which makes it the first in the state with the largest elderly population, among the eight municipalities with more than 200,000 inhabitants[13].

The residents of this city have the Municipal Council for the Rights of the Elderly, which is linked to the Secretariat of Social Assistance and Citizenship (SASC- Secretaria de Assistência Social e Cidadania), responsible for the implementation of the municipal policy of the elderly's rights. The Basic Social Protection Network offers socialization activities and is responsible for the coexistence center[14], where the study was carried out.

This place is a philanthropic entity with capacity for care of 20 elderly, it is located in a place provided by the city and is maintained by donations and resources from promotions made by the city hall. Admission to the institution can be requested by the family, social assistance, or by judicial means, and the institution only confirms when it found that the elderly are in a situation of social vulnerability. To this end, prior to admission, the social worker of the service makes a visit at the older person's home, where the professional evaluates the financial situation, family relationships, housing conditions and the level of functional dependence of

the elderly, since they admit only elderly people who can perform basic daily life activities (bathing, dressing up, going to the bathroom, moving, urinary continence, and eating)[14-15].

Despite this, most elderly admitted to the service need assistance to perform instrumental daily life activities, such as cleaning the house, taking care of clothes, making food, using household equipment, shopping, using personal or public transportation, control medication, and finances[14-15].

The institution operates from Monday to Friday from 7:30 am to 5:00 pm and, at the time of data collection, had the following professionals: a social worker, a secretary, an elderly caregiver, a caretaker, and a cook. The professional with higher education performs bureaucratic coordination functions and, along with the caregiver, organizes the schedule of activities of the participants, which involves meals, walking, and physical activities at the Third Age Gym (ATI- Academia da Terceira Idade), located in the external area of the establishment, in addition to handicrafts and games. The other people in the staff prepare meals, clean and organize the place.

### *Data collection*

We used the convenience sample to select the participants and adopted the following inclusion for the elderly selection: to participate in the coexistence center for at least three months and be able to answer the study questions, according to the evaluation of the Mini Mental State Examination (MMSE) adjusted to schooling[16]. For family members, the criteria we adopted were to be familiar to the elderly who have participated in the coexistence center for at least three months, living with the elderly for at least six months and being able to answer the questions, evaluated by the MMSE[16]. The inclusion criteria "participation time of the coexistence center" and "living with the elderly" are justified because it is possible, at this time, to perceive the influence in the participation in the service.

Before data collection, the researchers, with experience in qualitative research and members of a gerontological research group, performed approximation to the field and study participants. At that time, they presented the research and its objectives, resolved doubts, and developed some activities with the elderly. Subsequently, they approached the elderly, and with the verbal acceptance to participate in the study, they scheduled an appointment on the date, time, and place of the elderly's preference. The institution's social worker contacted the family members by telephone, and, with the acceptance, a meeting was also scheduled on a date that best suited them.

We collected data from 16 elderly and 14 family members, between December 2015 and February 2016, through a semi-structured script elaborated by ourselves. We used as a guiding question to the elderly: "What has changed in your life after being admitted to the coexistence center?" And to the family members: "What has changed in the elderly's lives after being admitted to the coexistence center?"

We conducted the interviews individually and in a quiet place within the institution itself (26) and at the home (four), according to the availability and preference of individuals. After the participants' consent, we recorded the interviews. They lasted on average 15 minutes. We interviewed each participant only once, and the choice to include them occurred when the obtained material made it possible to achieve the objective of the study, adopting the theoretical saturation criterion[17].

### *Data organization and analysis*

All interviews were fully transcribed and submitted to content analysis, in the thematic modality, which included the processes of pre-analysis, exploration of the material, data processing with its systematic organization in thematic units, construction of inferences, and interpretation of the significant categories, as proposed by Bardin[18]. In the pre-analysis, the floating and individual reading of the interviews was performed, followed by the exploration of the material, with the detailed and exhaustive reading of the content. Then, the message was encoded through colors, which made it possible to apprehend the meaning cores and group them according to their similarities, emerging two thematic categories[18]: "Before and after: changes in the life of the elderly after joining the coexistence center" and "Aspects needed to improve care in the coexistence center".

## RESULTS

Among the 16 elderly interviewed, nine were female, aged between 61 and 91 years, with an average of 77 years old. Nine were widowed, 14 had up to four years of schooling, 11 were retired, and the time of participation in the institution was between 4 months and 10 years.

In relation to the 14 family members, 12 were female, aged between 19 and 81 years old. Seven of these were married, nine had more than ten years of schooling, 11 were employed and worked on average eight hours a day. In addition, the relatives of the elderly are: seven children, two grandchildren, a mother, a wife, a sister, a niece and a daughter-in-law. The time they lived together ranged from two to 74 years.

The analysis of the data framework conducted the study for two categories that will be presented below.

### Before and after: changes in the life of the elderly after joining the coexistence center

The elderly's admission to the center influenced their lifestyle. They adopted, with the help of the service, new habits, such as the regular practice of physical activities and healthy eating, considered as a way to prevent the risk of chronic conditions, as well as its complications.

> *He did not take care of eating habits, after he began to participate in here, he greatly improved, his diabetes and blood pressure normalized.* (F9)

> *My health has improved a lot, today my life is better. When I came in, I was under high blood pressure and now it's normal.* (E9)

> *The walk has been stimulating them not to hurt* […] *my legs are better. My legs don't hurt anymore, I can walk alone.* (E4)

We noted the benefits from cognitive stimulation through leisure activities, such as games and handicrafts, which gave the

elderly the ability to return to manage their own lives. Leisure was seen as an uplifting and socializing element, helping the elderly to relate to each other during their practice and also improving the relationship with family members.

> *I was forgetful, I used to let the food burn* […]. *I came here, started playing dominoes, doing embroidery, it made my mind better. I didn't take any pills for this, and it all went back to normal.* (E7)

> *After I started coming here, I realized that we use our minds more, it improved my memory. Because we talk, participate in games, take care of the garden, all day working the mind. Before, I didn't use my mind, i didn't have any of that.* (E2)

It is observed that participation in the center becomes a commitment for the elderly to occupy their time, with improvements in functional performance, self-esteem, and reduction of behavioral disorders.

> *Before, i used to got up early and I had nothing to do. Now, I'm committed to coming here, I don't sit around anymore.* (E8)

> *Thank goodness I have this group to participate. Here we enjoy ourselves, the goes by and we don't even realize* […] *Then I think: What would I be doing if I stayed at home? I'd be walking down the street doing the wrong thing* [consuming alcohol*].* (E15)

> *He no longer has time to think about drinking, he has a routine established here at Centro Dia.* (F4)

Participation in the service redefined values, elderly's attitudes and behaviors, who began to face life in another way. There by, they improved their interpersonal relationships, especially with family.

> *My life has improved a lot, I talk more, I come home more lively, I play with my great-granddaughters, I draw with them* […]. (E5)

> *My family took care of me, but I was kind of estranged. Now that I have stopped drinking, we are closer together, every Sunday they come to my house. To me, it's such a pleasure.* (E15)

> *His contact with people improved after he started coming here: if someone came home, he isolated himself, he didn't have much to talk about. Now, it's different, he doesn't hide anymore and, when asked about the group, he starts talking, about everything,* [...] *he interacts more with people.* (F9)

The elderly recognize that joining the coexistence center minimizes the concerns of their family members, because, before attending the service, the family was deprived of work or, when inserted in the job market, they left the older person alone at home, which , according to the elderly, caused them concerns and discontent.

> *I'd rather come here than stay at home doing nothing! And my family also likes that I come, because everybody works. They cannot take care of us during the day.* (E13)

> *I love coming to this day-care center, it is really good for my life. My children find it better for me to come to here than to be alone the entire day at home.* (E7)

The participation of the elderly in the coexistence center reduced vulnerabilities and health risks related to social and economic determinants. That is because, by admitting individuals with low socioeconomic status, they were allowed to have a social support network, which improved their lifestyle and functional capacity, and allowed their family members to have a formal work activity.

### Aspects needed to improve care in the coexistence center

Although the results of the previous category allow us to identify the positive repercussions on the lives of the individuals after joining the coexistence center, there was a recognition of the need for improvements in the service. Among them, the precariousness of the physical structure and the absence of effective programming of activities to be developed by a multi professional team stand out. Because of these factors, participants often have spare time and seek distraction with the available resources:

> *Some time ago they had more activities to spend our time with; and there is almost nothing. When you have nothing to do, time slows down. The only thing there is to do is play dominoes, but some women don't like it and just stare at the game. I wish we had more activities.* (E1)

The elderly identify the lack of qualified professionals to develop activities, especially physical educators. A positive impact could be identified due to the encouragement to the practice of physical activities, previously performed by a professional.

> [...] *Before, there were people who would tell us to exercise the body. Now, there's no one to do these activities with us.* (E4)

Concomitantly with the expansion aspects of the multi professional team, the participants also reported the need to maintain the physical structure:

> *Some repairs must be done here. The most urgent is the roof, because when it rains, it has a drip that wets the whole room, it becomes a river!* (E2)

> *I have been coming here for four years, they never made repairs to the house. Things are in the same way!* (E7)

The challenges linked to the limitation of the multidisciplinary team and the service infrastructure bring a reflection on the implementation of the real objectives of social centers, as the success of the development of activities aimed at health promotion depends, as a basic requirement, on the professional diversity involved and physical resources of the health service.

## DISCUSSION

The aging process is commonly permeated by vulnerabilities and increased incidence of chronic conditions, which influence the functional capacity of the elderly, that is, the decision and execution capacity[4].

In response to this, the World Report on Ageing and Health states that all interventions aimed at promoting healthy aging should seek to maximize the individual's functional capacity[6]. To this end, the World Health Organization (WHO) suggests some priorities, including

the alignment of health systems with this population and the development of long-term care systems[6], as the coexistence center.

Social programs aimed at the elderly population stand out for promoting safety, personal satisfaction, well-being, encouraging participants' autonomy and adopting an active and healthier lifestyle[19], with disease prevention and control, such as dementias[20]. In addition, they enable the re-establishment of quality of life, based on the principles of WHO[20], mainly in the physical, psychological and social relations domains, as demonstrated in this study.

Among the alternatives practiced in the coexistence center studied, the highlight was the encouragement to practice physical activities. Such practice reduces the risk factors for cardiovascular disease by 40%[21], improves physical fitness, walking skills and the ability to perform professional and domestic tasks[20] , and especially when the practitioner is elderly, promotes greater opportunity for socialization[21]. Thus, physical activity can be a link against loneliness and even compensate for the reduction in social relationships[10,21]. We reinforced here that such practice directly influences the quality of life[20] and the preservation of the independence, autonomy and identity of these individuals[10].

However, despite the benefits generated by physical activity, there is no qualified professional in the institution studied to monitor both the performance of this practice by the elderly and their development regarding the assessment of the intensity and amplitude of the technique. This is a task of great relevance to senior groups [22], especially when it is considered to be the most inactive public in the world[23]. Besides, research recently conducted in British Columbia has shown that older people view supervising professionals as essential for continued participation in physical activity, not only for their knowledge of how to follow such practice but for their enthusiasm and positivity in encouraging the persistence of individuals in these groups[23].

The findings of this research also demonstrate benefits deriving from the participation in leisure activities reported by participants. In old age, individuals have biopsychosocial needs that can be met through participation in these activities. In groups, the elderly can share joys, sadness and knowledge, which provides emotional support and motivation to live longer and with quality[11].

Interestingly, here, there is a difference in preferences for activities between men and women. The former are more interested in games, while most women prefer craft activities. A study conducted in Florianópolis-SC found, in a social group, that men have a preference for dominoes, and women participate rarely. However, studies found elderly people of both sexes performing the same types of intellectual activities, which contradicts the stereotypes that certain leisure tasks are presented as female or male[24].

Gambling is a widely used practice in coexistence centers as a distraction, entertainment and exercise tool for maintaining cognitive capacity and memory. From this practice, it is possible to consolidate the relationship between the elderly through interpersonal contact and the different social elements established during the practice, with conversations, looks, laughter and exhibition of the prize won[24].

Among the various physiological changes resulting from the aging process, central nervous system functions, especially those related to the cognitive process, such as learning and memory, are affected when not stimulated[12]. Study reveals positive effects for participants in cognitive decline groups involved in art and music therapy programs, and improvement of some behavioral factors such as agitation and symptoms of depression[10]. This is consistent with the claim that behavioral and emotional problems in dementia are partly the result of lack of activity[25].

Physical, cognitive and social stimulation activities impact the behavior of the elderly, not only during their stay in the coexistence center, but also throughout their daily life[25] and throughout their participation in the groups[12]. Such activities developed in these establishments enable improvements in functional performance, self-esteem and reduction of behavioral disorders in the elderly. Thus, free time is occupied, and this arouses social commitment to the elderly, enabling them to have important values of inclusion and meaning in life[26].

The elderly interpret the support, encouragement and recognition of family members as a stimulus to remain in the coexistence center, considering that older people need more family and social support[11]. This support can alleviate the negative effects created by the various problems accumulated in old age[12,27]. The family not only symbolizes social support for the elderly, but also cares about their well-being, after all family support corresponds to their main care core, a continuous, prolonged and integral care, which often requires reorganization of routine[28].

The interaction of the individual with his family and society must be among the factors that influence personal identity, and if it is negative, it makes daily life permeated with suffering, which can even result in severe psychic disorders, with risks for suicide. The association between the prevention of suicide in the elderly and the enrichment of social networks has been the subject of studies and has shown a positive impact on physical and mental well-being, increased encouragement and intervention on how to deal with life challenges in the workplace aging[10,29].

Despite the positive repercussions generated by the participation of the elderly in social groups, the accelerated demographic transition has caused several problems to the elderly population, such as difficulties with social assistance, devaluation of pensions, the precariousness of leisure activities and difficulties for the family to live to take full care of your seniors. In association with the factors mentioned, public policies and social structures have not been adequately matched to meet such a demand, which has left families in a difficult situation. The increased prevalence of institutionalization makes this situation evident[3]. In this regard, the World Report on Ageing and Health states that, in general, responsibility for long-term care has been left solely to families, but this practice is no longer sustainable[6].

A reflection of the above is presented by the latest data provided by the Brazilian institute Instituto Brasileiro de Geografia e Estatística (IBGE) in which only 53.7% of the municipalities have Coexistence centers; 1.2%, have Day Center (Centro Dia); 7.29%, have households (Casa Lar) or Institutional Shelter; and less than 1%, have senior cohousing[30]. Although the municipality studied has these services, it does not mean that all elderly are being assisted since there are limited vacancies, as the waiting list for the institution, where the research was carried out, makes evident.

Even though the costs of services provided by the coexistence centers are lower than those of nursing homes[10], there are few units compared to the number of elderly and the precariousness of the services provided, conditions perceived by the elderly

themselves. That is because of the lack of a multidisciplinary team that allows care expansion and progress of their health, as well as to the physical structure due to maintenance problems.

These factors make it possible to state that these sectors do not have enough public investment to meet the specifics demands of this population[12]. It is worth mentioning that one of the most important guidelines of the coexistence center is the opportunity to be an interdisciplinary field, a space for transversality of biopsychosocial, cultural and circumstantial aspects related to the elderly and professionals, based on mutual learning[12,21]. However, what is actually observed is the limitation of the human resources in the development of managerial and assistance activities.

As the World Report on Ageing and Health brings, spending on long-term care and favorable environments for older people should be seen as investments that promote the capacity and, consequently, well-being of those individuals. These investments assist society in meeting its obligations regarding the primordial rights of the elderly[6].

Finally, aligned with this statement, as shown in the literature, groups formed in a coexistence center collaborate positively in factors related to two important areas of health promotion: the development of personal skills, such as learning, self-esteem, self-image, and incentive to live. ; and the reorientation of health services, which are humanization, comprehensiveness of care, the broad concept of health, and interdisciplinarity[11-12,26]. Therefore, it is necessary to take into account the need to expand these services, with a closer look at public authorities so that hey can implement adequate spaces, offering comprehensive care in several areas and, above all, having a multi professional team trained in gerontogeriatric.

### Study Limitations

The present study had limitations related to its location, as it was performed in a single service makes it difficult to replicate the findings to other audiences. Comprehensive research needs to be carried out to verify the situations of this level of care distributed in the country.

### Contributions to the nursing, health, or public policy fields

The perceptions of the elderly and their families about the coexistence center not only add an important understanding of how the service works and its repercussions on their lives but also demonstrate the need for improvements for more effective results. The emerging need for the implementation of long-term care for the elderly, especially those in which the service and family are co-responsible in care, is highlighted, given the positive results regarding the well-being and health of the elderly and the reduction of vulnerabilities at the individual, social and programmatic levels.

For nursing, the advance is to show that, although services in the coexistence center are linked, above all, to social assistance, there is room for these professionals to provide care that promotes or maintains the functional capacity of the elderly.

## FINAL CONSIDERATIONS

The results indicate that the coexistence center is a space that promotes the interaction of the elderly, with the construction of new social identities. We found that the elderly experience positive repercussions on their lives after joining the institution, with the possibility of learning new skills, changing attitudes and behaviors, preventing the development of chronic conditions and their complications, improving cognitive and functional performance as well as increasing the welfare. All these benefits were reflected in the social and family relationship between those involved.

It is noticeable the positive impact on the life of these elderly even with the deficiencies of the service, especially because there is no multidisciplinary team in the care offered. We believed that the expansion of health professionals - with training in various areas such as physical therapy, physical education, nutrition, psychology, and nursing - results in the achievement of better results, due to the comprehensive care provided.

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