Variables associated with religious practice in Brazilian adults and older adults aged 50 and over: ELSI-Brazil

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Abstract

Objective: To identify variables associated with religious practice in Brazilian adults and older adults aged 50 and over. *Method:* In this observational and cross-sectional study, the participants included 7,171 individuals aged 50 and over from a representative national sample (N=9,412), interviewed in the first wave of the Brazilian Longitudinal Study of Aging (ELSI-Brazil), on frequency of participation in religious services, religious affiliation, self-rated health, sex, age, education, living arrangements, region of residence, and race. The Poisson regression model was used to investigate crude and adjusted associations between variables. *Results:* Fifty-seven percent of the sample was female, the mean age was 62.5±9.4 years old, the majority had 5 to 8 years of education and lived with 3 or more people, 42% resided in the Southeast region, and 48% self-declared as *Pardo* [mixed race], 66% were Catholic, 76% attended religious services once or more times a week, and 45% rated their health as fair. The most frequent participants in religious services were Black (PR=1.06, 95%CI 1.00-1.12)and mixed race (PR=1.07, 95%CI 1.03-1.11), Evangelical (PR =1.26, 95%CI 1.22-1.30), and self-rated their health as fair (PR=1.07, 95%CI 1.02-1.11). In contrast, the least frequent were male (PR=0.87, 95%CI 0.84-0.90), with 5 to 8 years of education (PR=0.92, 95%CI 0.88-0.97), residing in the Southeast (PR=0.91, 95%CI 0.86-0.95) and South (PR=0.90, 95%CI 0.82-0.99) regions. **Conclusion:** Self-declaration as Black and mixed race, Evangelical religion, and self-rated health as fair were associated with higher attendance at religious services among Brazilians aged 50 and over.

Keywords: Religion. Aging. Self-assessment. Aged.

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INTRODUCTION

Religiosity is a multidimensional phenomenon and concept that includes a person's involvement in beliefs, behaviors, rituals, and sacred and transcendent symbols shared and practiced by religious institutions and communities[1,2]. Etymologically, "religion" comes from the Latin term *religare*, which refers to religious practices through which human beings are bound to God and to a community that shares the same principles[1]. Religiosity offers an understanding of how the world and human existence works[1–3], and brings together individuals with similar behaviors and beliefs about transcendence[1,2]. It performs psychological functions, since it provides social support, optimism, purpose in life, a sense of belonging, and favors adaptation to stressful situations[1,3].

Religious practice and religious affiliation are dimensions of religiosity, together with religious commitment and coping[1]. Religious practice involves public and private religious activities, also known as organizational and non-organizational practices[4]. Public religious practice refers to a person's attendance and participation in religious services and ceremonies and in other community activities, such as groups for reading religious writings and prayer groups[4]. Private religious practice comprises religious activities that the individual carries out alone, such as praying, meditating, reading religious writings and watching religious channels on television[4]. Religious affiliation is related to the religious tradition that a person practices, publicly or privately, and with which they identify, sharing beliefs and rituals with other individuals[1].

The frequency of religious practice changes as a person ages. According to Bengtson et al.[5], participation in religious services is low in early adulthood, increases during middle age, reaches its peak in early old age, remains stable for a period and then declines due to losses associated with senescence, multimorbidity, and physical and cognitive disabilities. This trajectory is also affected by generational and context variables, including the secularization of societies[6,7].

The frequency of attendance at churches and temples for religious practices varies according to sex, education, and race. Women tend to participate more assiduously in public religious activities than men because they value the social aspects of religiosity more than men[8–10]. In addition, public practices offer opportunities for deriving a sense of belonging, valuing oneself[1,3], social involvement[1,8], volunteer services[10], giving and receiving support[1,2] which are activities valued more by women than by men[8,10]. Older adults with formal education of eight or more years tend to be less assiduous practitioners of religious ceremonies than less educated older adults[9,10]. In research conducted among Europeans[10,11], Asians and White North Americans[11], the most common finding is that these groups have a low frequency of public religious practice, a fact not observed among African Americans residing in the United States[12], who show a high frequency of attendance at religious services.

The frequency of attendance at religious services may also vary according to religious affiliation. Among practitioners of Evangelical religion, frequent participation in cults is a precept that is more important to follow than among Catholics[13]. Ninety-four percent of Brazilian adults and older adults report following at least one religion that performs public and community rituals and ceremonies, including masses, cults, and meetings[14], in which the Catholic and Evangelical religions are the affiliations with the highest number of practitioners[13,14].

In addition to being a reliable indicator of general health status, self-rated health is a subjective variable capable of identifying signs of functional decline and mapping the risk of mortality[15]. Older adults who show assiduous public religious practices present better self-rated health than older adults with low or no attendance at public or organizational religious activities[15,16], because of the adoption of healthy behaviors and the emotional and social support received in churches and within congregations[17,18].

According to the literature, public religious practice among older adults can be influenced by social and health factors, and is associated with psychological well-being. There is some controversy,

but religiosity tends to be more valued by older adults than by the adult population in general, partly due to the tendency to adopt it as a coping mechanism for stressful events, the incidence of which increases in old age, in part due to generational issues.

There are few Brazilian studies with recent population-based data that investigate the characteristics of public religious practice in the older adult population. The Brazilian Longitudinal Study of Aging (ELSI-Brazil) is the first survey conducted on a representative sample of the Brazilian population aged 50 and over. The inclusion of the religiosity domain in the data collection protocol enables the investigation of public religious practice and its relation with sociodemographic and health indicators. In this study, the domain of religiosity was divided into two aspects – affiliation and religious practice. The purpose was to identify associations between public religious practice, religious affiliation, self-rated health, and sociodemographic variables (sex, age, education, living arrangement, region of residence, and race) in a national sample representative of the Brazilian population aged 50 and over, among participants of ELSI-Brazil.

METHODS

This is an observational, cross-sectional study conducted on baseline data from the *Estudo Longitudinal da Saúde dos Idosos Brasileiros* (ELSI-Brazil), collected in 2015 and 2016. The full sample of the ELSI-Brazil consisted of 9,412 individuals[19]. The size and composition of the full sample were representative of the non-institutionalized Brazilian population aged 50 and over, randomly selected by inverse sampling to avoid increasing the sample size to compensate for missing data[19]. For this study, data from 7,171 participants were used. The sample losses did not comply with any selection criteria, they included participants who declared themselves nonreligious and who therefore did not respond to the variable "public religious practice", and those who failed to respond to items from the other instruments used. Briefly, those who did not respond to all the variables of interest were excluded. The participants lived in 7,500 households in 70 small, medium and large municipalities in the five Brazilian macro-regions, selected through stratification into four categories, according to population size[19,20]. All residents of selected households aged 50 or older, who accepted the invitation to answer an individual questionnaire[19,20], were included in the study. If the participant presented any physical and/or mental limitation that prevented them from responding, a substitute informant was elected to answer the individual questionnaire on their behalf[19].

Public religious practice was examined based on an item from the Duke University Religion Index (DUREL)[4,21], which measures the frequency of participation in religious services: "In the last 12 months, how often did you participate in religious services, such as masses, services or prayer groups in temples or churches or on TV?". This was evaluated according to the responses: 1, more than once a week; 2, once a week; 3, two or three times a month; 4, one or more times a year; 5, never; which were then grouped as "once or more than once a week", "two or three times a month", and "one or more times a year/never". The first two categories represent greater regularity and religious involvement, while the last category combined the response "one or more times a year", corresponding to low regularity for participation in religious ceremonies that represents minimal religious involvement, and the response "never", which represents no involvement.

Religious affiliation was verified by means of nine items: 1, No religion; 2, Catholic; 3, Protestant; 4, Evangelical; 5, Spiritism/Kardecism; 6, Buddhism; 7, Islam; 8, religions of African origin; 9, other, which were then grouped as "Catholic"; "Protestant"; "Evangelical"; "Spiritism"; and "other religions". Participants in the "Protestant" category correspond to those affiliated with the Lutheran, Baptist, Adventist, Presbyterian and Methodist Churches, among others. Participants in the "Evangelical" category correspond to those affiliated with Pentecostal and Neo-Pentecostal churches. The other religions were grouped in the category "other religions" to enable statistical calculations.

Health self-assessment was investigated through the item: "In general, how do you rate your health?",

according to the answers: 1, very good or excellent; 2, good; 3, fair; 4, poor; 5, very poor, which were reduced to three categories: "good/very good"; "fair"; and "poor/very poor".

The sociodemographic variables measured were sex (female and male), age (50 to 59 years old, 60 to 69 years old, 70 to 79 years old, and 80 years old and over), education (none, 1 to 4 years, 5 to 8 years, and ≥9 years), living arrangements (alone, with 2 people, and with 3 or more people), region of residence (North, Northeast, Southeast, South and Midwest), and self-reported race/color (White, Black, *Pardo* [mixed race], Asian and Indigenous).

The sample responses recorded were submitted to descriptive analysis, with absolute and relative frequency measurements of all the variables. Subsamples of participants were compared according to the frequency of participation in public religious practices, using Pearson's chi-square test, for a value of $p<0.05$. To verify associations between frequency of religious practices, religious affiliation, self-rated health, and sociodemographic variables, crude and adjusted prevalence ratios and respective confidence intervals (95%) were analyzed using the Poisson regression model. All variables were included in the final model and those that presented a value of $p<0.05$ remained.

The ELSI-Brazil project was approved by the research ethics committee of the René Rachou Research Center of the FIOCRUZ, under report protocol no. 2111911. For each stage of data collection, all participants signed a term of free, informed consent.

RESULTS

Table 1 presents the descriptive results of the sample of 7,171 individuals regarding sociodemographic variables, religious affiliation, public religious practice, and self-rated health.

The results of comparisons between the frequency of participation in public religious practices, religious affiliation, self-rated health and sociodemographic variables are presented in Table 2. Among the most assiduous individuals, there were more women than men, more mixed race than White individuals, more Catholics than Evangelicals, and more individuals who rated their health as fair than good/very good or poor/very poor. Among the less assiduous participants, those with 5 to 8 years of education, who lived in the Southeast region, were White, Catholic, and self-rated their health as good/very good predominated (Table 2).

Table 3 shows the crude and adjusted prevalence ratios of all variables, according to the probability of the participant's frequency of participation of at least once a week. In the crude analysis, higher attendance was observed among Black (PR = 1.06) and mixed race participants (PR = 1.07) than among White participants, among Evangelicals (PR = 1.28) than among Catholics, and among those who rated their health as fair (PR = 1.07) than among those who rated their health as good/very good. Lower attendance was observed among men (PR = 0.85) than among women, among those with 1 to 4 (PR = 0.83) and 5 to 8 years of education (PR = 0.92) than those with no formal education, and among those residing in the Southeast (PR = 0.88) and South (PR = 0.86) regions than in the North region. Analysis of PR adjusted for sex, age, education, living arrangement, region of residence, race/color, religious affiliation, and self-rated health indicated that Evangelicals were more assiduous than Catholics (PR = 1.26) and that being a man (PR = 0.87) and living in the Southeast (PR = 0.91) and South (PR = 0.90) regions were associated with lower attendance for public religious activities (Table 3).

Table 1. Sample characterization (N=7,171). Brazilian Longitudinal Study of Aging, Brazil, 2015-2016.

Variable	n (%)	95%CI[1]	Mean (SD)	Median (Min. – Max.)
Sex				
Female	4,097 (57.1)	55.9 – 58.2		
Male	3,074 (42.9)	41.7 – 44.0		
Age (years)			62.5 (±9.4)	61.0 (50-99)
50 to 59	3,226 (45.0)	43.8 – 46.1		
60 to 69	2,264 (31.6)	30.5 – 32.6		
70 to 79	1,274 (17.7)	16.8 – 18.6		
80 and over	407 (5.7)	5.1 – 6.2		
Education (years)			6.71 (±4.3)	5.0 (0-16)
None	1,006 (14.0)	13.2 – 14.8		
1 to 4	97 (1.4)	1.1 – 1.6		
5 to 8	4,353 (60.7)	59.5 – 61.8		
≥ 9	1,715 (23.9)	22.9 – 24.9		
Living arrangements				
Alone	867 (12.1)	11.3 – 12.8		
2 people	2,228 (31.1)	30.0 – 32.1		
3 or more people	4,076 (56.8)	55.6 – 57.9		
Region of residence				
North	643 (9.0)	8.3 – 9.6		
Northeast	1,845 (25.7)	24.7 – 26.7		
Southeast	3,028 (42.2)	41.1 – 43.3		
South	923 (12.9)	12.1 – 13.6		
Midwest	732 (10.2)	9.5 – 10.9		
Race/Color				
White	2,786 (38.9)	37.7 – 39.9		
Black	704 (9.8)	9.1 – 10.5		
Pardo [mixed race]	3,429 (47.8)	46.6 – 48.9		
Asian	71 (1.0)	0.7 – 1.4		
Indigenous	181 (2.5)	2.1 – 2.9		
Religious affiliation				
Catholic	4,752 (66.3)	65.1 – 67.3		
Protestant	54 (0.7)	0.5 – 0.9		
Evangelical	1,951 (27.2)	26.1– 28.2		
Spiritism	262 (3.7)	3.2 – 4.1		
Other religions	152 (2.1)	1.8 – 2.4		
Public religious practice				
Once or more than once a week	5,458 (76.1)	75.1 – 77.1		
Two or three times a month	753 (10.5)	9.8 – 11.2		
One or more times a year/never	960 (13.4)	12.6 – 14.2		
Self-rated health			2.6 (±0.8)	3 (1-5)
Good/Very Good	3,104 (43.3)	42.1 – 44.4		
Fair	3,238 (45.1)	44.0 – 46.3		
Poor/Very poor	829 (11.6)	10.8 – 12.3		

[1] 95%CI, 95% confidence interval

Source: the authors.

Table 2. Percentage of adults and older adults according to frequency of participation in public religious practices, considering the sociodemographic variables, religious affiliation and self-rated health (N=7,171). Brazilian Longitudinal Study of Aging, Brazil, 2015-2016.

Variable	Once or more than once a week n (%)	Two or three times a month n (%)	One or more times a year/never n (%)	*p**
Sex				**<0.0001***
Female	3,320 (58.3)	385 (50.8)	392 (37.4)	
Male	2,138 (41.7)	368 (49.2)	568 (62.6)	
Age (years)				0.1907
50 to 59	2,398 (49.7)	358 (54.3)	470 (50.6)	
60 to 69	1,745 (30.4)	232 (29.5)	287 (31.0)	
70 to 79	1,016 (15.2)	115 (11.8)	143 (13.0)	
80 and over	299 (4.6)	48 (4.4)	60 (5.6)	
Education (years)				**0.0008***
None	799 (11.9)	102 (9.8)	105 (8.6)	
1 to 4	66 (1.1)	12 (1.6)	19 (1.6)	
5 to 8	3,255 (63.1)	472 (69.2)	626 (70.3)	
≥ 9	1,338 (23.8)	167 (19.5)	210 (19.4)	
Living arrangements				0.3685
Alone	663 (8.7)	89 (8.5)	115 (8.5)	
2 people	1,755 (32.4)	209 (29.7)	264 (29.6)	
3 or more people	3,040 (58.9)	455 (61.8)	581 (61.8)	
Region of residence				**0.0014***
North	526 (6.9)	65 (6.3)	52 (3.5)	
Northeast	1,468 (24.1)	177 (19.2)	200 (17.7)	
Southeast	2,203 (46.8)	329 (48.5)	496 (56.7)	
South	683 (14.6)	116 (20.7)	124 (16.4)	
Midwest	578 (7.5)	66 (5.7)	88 (5.5)	
Race/Color				**0.0035***
White	2,063 (40.1)	305 (45.0)	418 (48.1)	
Black	549 (10.1)	60 (7.5)	95 (9.9)	
Pardo [mixed race]	2,657 (46.7)	360 (44.5)	412 (38.6)	
Asian	49 (1.0)	13 (1.6)	9 (0.8)	
Indigenous	140 (1.9)	15 (1.4)	26 (2.4)	
Religious affiliation				**<0.0001***
Catholic	3,366 (63.3)	580 (77.6)	806 (83.7)	
Protestant	43 (0.7)	5 (0.5)	6 (0.7)	
Evangelical	1,762 (30.5)	111 (13.8)	78 (8.4)	
Spiritism	176 (3.3)	40 (5.6)	46 (4.9)	
Other religions	111 (2.1)	17 (2.3)	24 (2.4)	
Self-rated health				**0.0195***
Good/Very Good	2,317 (43.2)	337 (49.6)	450 (49.1)	
Fair	2,519 (45.6)	325 (40.6)	394 (40.0)	
Poor/Very poor	622 (11.2)	91 (9.8)	116 (10.9)	

* Pearson's Chi-square test. Statistically significant differences when $p<0.05$.

Source: the authors.

Table 3. Crude and adjusted prevalence ratios (PR) of higher attendance compared to less attendance in public religious practices, according to sociodemographic variables, religious affiliation and self-rated health (N=7,171). Brazilian Longitudinal Study of Aging, Brazil, 2015-2016.

Variable	Crude PR[1] (95%CI)[2]	*p**	Adjusted PR[3] (95%CI)	*p**
Sex				
Female	1		1	
Male	0.85 (0.82-0.89)	**<0.001***	0.87 (0.84-0.90)	**<0.001***
Age (years)				
50 to 59	1			
60 to 69	1.01 (0.97-1.04)	0.667		
70 to 79	1.05 (0.99-1.11)	0.071		
80 and over	0.98 (0.91-1.05)	0.576		
Education (years)				
None	1			
1 to 4	0.83 (0.70-0.98)	**0.029***		
5 to 8	0.92 (0.88-0.97)	**<0.001***		
≥ 9	0.98 (0.94-1.03)	0.537		
Living arrangements				
Alone	1			
2 people	1.02 (0.96-1.07)	0.457		
3 or more people	0.99 (0.94-1.03)	0.640		
Region of residence				
North	1		1	
Northeast	0.97 (0.91-1.02)	0.265	0.98 (0.92-1.03)	0.500
Southeast	0.88 (0.85-0.92)	**<0.001***	0.91 (0.86-0.95)	**<0.001***
South	0.86 (0.78-0.96)	**0.005***	0.90 (0.82-0.99)	**0.041***
Midwest	0.97 (0.90-1.05)	0.520	0.98 (0.89-1.07)	0.648
Race/Color				
White	1			
Black	1.06 (1.00-1.12)	**0.051***		
Pardo [mixed race]	1.07 (1.03-1.11)	**<0.001***		
Asian	1.00 (0.84-1.19)	0.998		
Indigenous	1.04 (0.92-1.17)	0.534		
Religious affiliation				
Catholic	1		1	
Protestant	1.11 (0.90-1.38)	0.309	1.12 (0.90-1.40)	0.283
Evangelical	1.28 (1.24-1.32)	**<0.001***	1.26 (1.22-1.30)	**<0.001***
Spiritism	0.93 (0.84-1.03)	0.169	0.94 (0.85-1.04)	0.279
Other religions	1.04 (0.93-1.16)	0.499	1.04 (0.94-1.16)	0.386
Self-rated health				
Good/Very Good	1			
Fair	1.07 (1.02-1.11)	**0.002***		
Poor/Very poor	1.05 (0.99-1.11)	0.151		

[1] PR, prevalence ratio; [2] 95%CI, 95% confidence interval; [3] Poisson regression model adjusted for sex, age, education, living arrangements, region of residence, race/color, religious affiliation, and self-rated health.

* Significant *p* value when $p<0.05$.

Source: the authors.

DISCUSSION

Self-declared Black and mixed race adults and older adults aged 50 and over, Evangelicals and individuals who self-rated their health as fair were the most assiduous participants in ceremonies and other public religious activities. In contrast, men, participants with 1 to 8 years of formal education, and those resident in the Southeast and South regions were the least assiduous in public religious practices.

The majority of the study participants were Catholics, most likely because the current generation of older adults and Brazilians of advanced age were socialized in this religion as children and adolescents, since Catholicism was highly widespread from the early to mid-twentieth century[13,22,23]. Catholicism has been losing ground in Brazil in recent years[13,22,23] due to the occurrence of social changes that determined a reduction in family influence in the transmission of Catholic precepts and traditions[13,23]. The prevalence of Evangelicals in this study is important, since there has been a diffusion of Evangelical churches on the outskirts of Brazilian metropolises, with more believers engaging this religion[13,22]. The realization of social programs by Evangelical communities and the use of different means of communication in the propagation of the Evangelical doctrine have also facilitated the affiliation of new adherents, particularly among persons of low income and with less education[22].

A large part of the sample consisted of assiduous practitioners. According to Idler et al.[6] and Hayward and Krause[7], participation in public religious practices is higher among older adults than among younger adults. Older adults value religious issues more and, following retirement and the decrease in family obligations, they tend to have more time to devote to religious activities[6,7]. The generational difference in public practices is also a result of the secularization process, which involves a decrease in religious practices and beliefs in societies as a whole[6,7]. Higher frequency of public religious practices is associated with positive mental health outcomes, such as increased psychological well-being[17,18] due to the social and emotional support that religious communities promote among their members[17,18,24] and the acceptance of health problems as part of life[24], lower use of antidepressants[24], lower rates of substance use[9,18], anxiety and depression[17,18], and it may reduce the risk of mortality[18]. Brenner[11] states that participation in religious ceremonies is an important part of socialization in South American countries.

Almost half of the participants rated their health as fair. This finding differs from the more recent descriptive results of studies that use methodologies similar to the ELSI-Brazil, such as the English Longitudinal Study of Aging (ELSA)[25], in which 74% of the sample rated their own health as good, very good or excellent[25]. Compared with English older adults, Brazilian middle-aged and older adults are considered to present less favorable health conditions, with the presence of multimorbidities, which explains the predominant self-rating of health as fair.

Black and mixed race participants were more assiduous than White participants. Krause[12] observed that older adult Black Americans attended more religious services than their White peers due to the fact that the social and emotional support offered by people from their religious community was greater than that offered among White people. According to Dos Santos[26], Black and mixed race people in Brazil experience social and economic difficulties caused by the particularities of racial discrimination in the Brazilian context, such as low or no formal education, unemployment, and lack of income. However, through their involvement with a community that assiduously attends religious ceremonies of any religious affiliation, they probably find a source of support that can help them face such adversities[26].

Evangelicals showed greater participation in religious practices than Catholics. Religious ceremonies are occasions when practitioners praise, give thanks, ask for divine help and guidance, and receive teachings from religious leaders. These elements are more valued by Evangelical practitioners than by Catholics[13]. Coutinho and Golgher[22] state that the Evangelical religion bases its precepts on the theology of prosperity, according to which the believer prospers by individually striving to overcome difficulties and maintain the behaviors instituted by Evangelical leaders. Thus, high attendance at services is an expected behavior of the Evangelical believer.

Evangelical churches usually provide more precise solutions for overcoming the problems that their practitioners may experience, such as low income and other socioeconomic adversities, chemical dependency, family problems, and urban violence[27], all of which are harmful to mental health. Presence at the services offers social and emotional support to cope with these problems and can strengthen the religious commitment of the practitioner regarding the Evangelical doctrine[27].

Individuals who self-rated their health as fair showed higher attendance than those who rated it as good or very good. Health self-assessment accurately represents the individual's state of health[15] and can be influenced by both sociocultural context and individual habits, such as the adoption of healthy behaviors and the use of coping strategies that reduce stress[15–18]. It is possible that the individuals in this sample rated their health as fair because they have less healthy habits and experience health problems that lead to functional limitations. Thus, attending religious services regularly can act as a social and emotional resource to deal with the difficulties caused by such functional restrictions[1,2].

Men showed less assiduous attendance than women. Schnabel[28] observed that men tend to be more dogmatic and hold more leadership positions than women and attributed these differences to gender stereotypes, which, according to the author, contribute to women being encouraged to participate in community religious activities, while men are encouraged to assume roles of leadership and authority[8,28]. According to Silva et al.[8] and Sowa et al.[10], women are socialized to express their feelings and seek support in religious communities to a greater degree than men. Men may encounter social support and ways to deal with their personal difficulties in sources other than participation in community religious services[8,10] or even in leadership positions in a church or congregation[8,28].

Participants with 1 to 8 years of education were less assiduous in their attendance at religious services than those with no formal education. Several studies[6,7,9,10,22] have observed that less participation in religious ceremonies is associated with an increase in the level of formal education and attribute this phenomenon to the secularization process. The importance given to attendance at religious services may be lower among more educated individuals[6], who dedicate themselves to other activities, such as those related to work[10].

Participants residing in the Southeast and South regions showed a lower frequency of religious practices than those in the North region. Compared with other macro-regions, the Southeast and South regions are more economically developed, their populations have higher levels of education and a higher proportion of Catholic practitioners[13,22], factors that are associated with less assiduous attendance at religious services. Considering the expansion of Evangelical religion in the North region and among the poorest Brazilians[13,22,27], and that the social support offered by religious communities helps the poorest in coping with difficulties, it seems reasonable to affirm that residents in the South and Southeast find other sources of social support and other ways of exercising religiosity, in addition to participating in public religious ceremonies.

This study presents limitations in that it did not consider the presence of comorbidities, functional disability and the participants' levels of autonomy and independence, variables that can influence participation in public religious practices. The cross-sectional design of this study means that investigating the causal relationships between the variables was not possible. However, there are advantages that should be mentioned: the use of population-based data from a longitudinal study, which has a methodology similar to other longitudinal studies on human aging, including the English Longitudinal Study of Aging (ELSA), the Health and Retirement Study (HRS), the Survey of Health, Aging and Retirement in Europe (SHARE), the Mexican Health and Aging Study (MHAS), enabling the generalization of the results obtained and transnational comparisons and meta-analysis studies; and the involvement of a panel of national experts and the use of standardized instruments that demonstrate methodological rigor. Furthermore, the support offered by government agencies and national research foundations for this study suggests the possibility of continued Brazilian research on the theme of religiosity and

its associations with social and health indicators among older adults.

CONCLUSION

This study aimed to identify associations between religious practice, religious affiliation, self-rated health and sociodemographic variables in a representative sample of Brazilian older adults and adults aged 50 and over, population segments marked by strong social inequality, which is based on important social, economic and health needs. We observed that Black and mixed race participants, Evangelicals, and those who rated their health as fair were more assiduous in public religious practices than White participants, Catholics and those who rated their health as good or very good. The main explanatory hypotheses for these results are of a socioeconomic and behavioral nature, that is, religious practices can act as a community source of social and emotional support when coping with social, economic and health difficulties.

Considering that the Brazilian older adult population is highly religious and that religious practices influence the physical and mental health of older adult practitioners, we argue that it is important to research the phenomenon of public religious practice in a population-based study, since it allows us to understand the characteristics of the Brazilian older adult population that assiduously attends religious ceremonies, taking into account their different cultural and social segments, particularly during a phase of demographic changes and religious transition, with profound sociological repercussions such as those faced today.

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