Social support and expectation of elderly care: association with sociodemographic variables, health and functionality

Suporte social e expectativa de cuidado de idosos: associação com variáveis socioeconômicas, saúde e funcionalidade

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ABSTRACT This study aims to evaluate the association between perceived and received support and the expectation of care with the sociodemographic variables, health conditions and functionality of the elderly in the community of the municipality of Várzea Grande, Mato Grosso state. It is a cross-sectional study carried out with 348 elderly people. The data collection was carried out by interviews, using an instrument with sociodemographic questions; health condition; functionality; and perceived and received support network. Analyzes were performed using Chi-square or Fisher's Exact tests. Social support was evaluated positively among the elderly, recognizing the family as the main provider, especially women. The expectation of care was associated to the spouse, by gender, age, marital status and family arrangement, especially to daughters or daughters-in-law, while siblings and paid professional were little mentioned. In old age, there is a greater reliance on support, due to health and disability, however, there is a tendency to reduce the support network in old age. It is important to develop care strategies for the elderly and family caregivers. It is hoped that this study will subsidize the implementation of elder care actions.

KEYWORDS Health of the elderly. Social support. Primary Health Care.

RESUMO *Este estudo tem como objetivo avaliar a associação entre suporte percebido e recebido e a expectativa de cuidado com as variáveis sociodemográficas, condições de saúde e funcionalidade dos idosos da comunidade do município de Várzea Grande, no estado de Mato Grosso. Trata-se de uma pesquisa transversal, realizada com 348 idosos. A coleta de dados foi efetivada por entrevistas, utilizando-se de um instrumento com questões sociodemográficas; estado de saúde; funcionalidade; e rede de suporte percebido e recebido. As análises foram realizadas pelos testes do Qui-quadrado ou Exato de Fisher. O suporte social foi avaliado positivamente entre os idosos, reconhecendo a família como principal provedora, principalmente as mulheres. A expectativa do cuidado foi associada ao cônjuge, por gênero, idade, estado civil e arranjo familiar, principalmente às filhas ou noras, enquanto os irmãos e o profissional pago foram pouco mencionados. Na velhice, há uma dependência maior do suporte, em razão da saúde e da incapacidade, entretanto, há uma tendência da redução da rede de apoio na idade avançada. É importante desenvolver estratégias de atenção aos idosos e cuidadores familiares. Espera-se que este estudo subsidie a implementação de ações de cuidados aos idosos.*

PALAVRAS-CHAVE *Saúde do idoso. Apoio social. Atenção Primária à Saúde.*

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Introduction

Aging occurs in a sociocultural context and requires attention and organizational care. For the individual, living old age satisfactorily depends not only on his/her competence against external and environmental demands, but also on his/her collective insertion, whose relation takes effect in the construction and maintenance of his/her well-being[1]. In the family environment and in the relationship between friends and neighbors, ties of coping with daily difficulties and activities are established[2]. Individuals in the family and community environment are substantial people, therefore, providers of social support, and form an informal support network, aimed at the daily help, that generates the well-being of those involved[2-7].

The informal support network is embodied in social relationships, interaction and material, instrumental and affective support, providing social inclusion, health promotion and quality of life for the elderly[5-8]. Among those with less financial resources, this type of help is even more necessary, since, under conditions of health problems and difficulties in accessing a formal health network, such as medication and treatments, they may become more dependent on an informal support network, usually located in geographically closer spaces, which makes it easier to request aid[4,7-16].

Population aging is a worldwide reality that points to the need for studies that subsidize care and support actions for families and caregivers of the elderly. It is relevant to know the network of support and social support to the elderly in the community of the municipality of Várzea Grande, in the state of Mato Grosso. In this context, the present study aims to evaluate the association between perceived and received support and the expectation of care with the sociodemographic variables, health conditions and functionality of the elderly in this community.

Material and methods

A cross-sectional study was carried out with elderly people from the community, attended at two Basic Health Units (BHU) in the municipality of Várzea Grande (MT). The Municipal Health Department mentioned the BHU that included elderly residents of urban, rural and riverside areas, considering the intention to reach them for the study. At the time of data collection, there were no systematized records in the BHU, and the number of elderly people was informed from the records of the Community Health Workers (CHW). The Souza Lima BHU had 362 elderly people and Água Vermelha, had 450.

Considering that there was no adherence of all CHW in the visitation for collection, there was an option for the convenience sample, that is, 191 elderly (52%) from Souza Lima and 164 (36.4%) from Água Vermelha, totaling 355 interviews. Eight CHW participated in the process of visitation and data collection, of which five collaborated in the visits and in the interviews, and only three in the visits, both at the Souza Lima BHU and at Água Vermelha BHU. Besides these, three other volunteer researchers participated in the data collection. All collaborators previously participated in a training on the research protocol, its objectives and procedures.

As inclusion criteria, were considered: people aged 60 years or over; attended at the health facilities at the study location; with communication conditions (speech, hearing and comprehension); who had agreed to participate voluntarily in the interview and signed the Informed Consent Form (ICF). Institutionalized elderly people were excluded. After applying the eligibility criteria, 7 subjects were, yet, excluded, with 348 remaining elderly.

The data collection was carried out through interviews that took place, mostly, in the households, with follow-up of the CHW, and in the health units, after group meetings or consultations. The instrument used was

developed from a research protocol (questionnaire), validated in the studies 'Fragility in Brazilian Elderly (Fibra)', of the Graduate Program in Gerontology of the Faculty of Medical Sciences of the State University of Campinas (FCM/Unicamp), and 'Health, Welfare and Aging (Sabe)', in Brazil, conducted by the Faculty of Public Health of the University of São Paulo (USP), under the coordination of the Pan American Health Organization/World Health Organization (PAHO/WHO). The questions were selected and adapted according to the purpose of the study[17,18]. The questionnaire was structured into six blocks: 1) identification of the participant; 2) sociodemographic variables (age, sex, marital status, race/color, occupation, schooling, housing arrangement and income); 3) health condition; 4) functionality; 5) expectation of care and perceived social support; and 6) family and social support network.

In this study, the support network and social support perceived and received, in addition to the expectation of care of people who live or not with the elderly, were associated to the sociodemographic variables and health and functional conditions categorized below:

• Sociodemographic: gender (male, female); age (60 to 74 years; 75 years or more), marital status (married or living with partner, divorced, separated or judicially separated, single, widow/widower). Age was calculated based on the relationship between the dates of birth and the interview.

• Health: health self-assessment (very good, good, regular, bad, very bad); number of diseases (0 to 2; 3 or more).

• Functionality: Instrumental Activities of Daily Living (IADL), based on the Lawton and Brody Scale (using the telephone; using transportation; shopping; preparing food; doing household tasks; using medication; handling money); and Basic Activities of Daily Living (BADL), related to self-care, referenced in the Katz Scale (bathing; dressing up; using the toilet; transferring; controlling the sphincter; feeding). The IADL and the BADL were evaluated with respect to independence, partial dependence and total dependence. And, for the analysis of this study, they were categorized into: dependent; independent.

• Expectation of care: assessed from the need for help for Activities of Daily Living (ADL) – (instrumental and basic). The question 'If you need or may end up needing help with any of the above activities, do you have someone to turn to?' had the following answer options: 'yes'; 'no'; 'DR' (Did not Reply). For those who answered 'yes', the following question was asked 'Who is this person?', with the following options: spouse or partner; daughter or daughter-in-law; son or son-in-law; another relative; neighbor or friend; paid professional.

• Perceived support: evaluated from 'never'; 'sometimes'; 'most of the time'; 'always' as answers to the questions 'Would you say you have many people to talk to, when you feel alone?'; 'Would you say you meet and talk to friends and family?'; 'Would you say that you find it easy to find people who can help you in your tasks if you become ill?'; 'Would you say you have someone to turn to when you need a suggestion on how to deal with a problem?'; 'Would you say that you have, at least, one person in whose opinion you absolutely trust?'.

• Help received at home: assessed from the list of people living in the same household as the elderly. The following question was carried out: 'Now, tell me: does any of these people help you? If so, with what?'. In the analysis, the answers were categorized into: 'yes'; 'no'. The complement to the positive response was free.

• Help received out of home: assessed from

the answers to the question 'Now I want to ask: Do you have children who do not live in the household with you?'. The number of children (own, stepchildren, foster children) was recorded and the question was then 'Now tell me if: do you receive any kind of help from these children? If so, with what?'. The same questions were asked regarding the siblings. About other family members and friends, the question was: 'Is there any other relative or friend who does not live with you in the same household, from whom you receive help or for whom you provide some help? Could you tell me, please?' The answers were 'yes'; 'not'; 'DK' (Do not Know); 'DR' (Did not reply). The following questions were addressed: 'Who?' and 'What help?'. The answers were grouped into 'children'; 'siblings'; 'others'.

The data were entered into the Excel spreadsheet, checked by filter and review of all questionnaires, one by one. Statistical analyzes were carried out using Software R, version 3.5.0. R Core Team (2018). Descriptive analyzes were carried out with absolute (n) and relative (%) frequency values. For the analysis of the association between the perceived and received support and the expectation of care with the sociodemographic variables, health conditions and functionality of the elderly, Chi-square or Fisher's Exact tests were used at the 5% level of significance (p value <0.05).

The research was approved by the Ethics Committee, with the opinion nº 1.995.932, of April 3, 2017, and met the requirements for research with human beings, according to Resolution nº 466/2012 of the National Health Council. The collection took place after the reading and signing of the Informed Consent Form (ICF) by the study participants.

Results

Of the 348 elderly people interviewed: the majority were women (62.07%); cohabited with someone (85.34%); married or with companions, followed by the widows/widowers; had low schooling and income. The age group ranged from 60 to 91 years old, with a mean of 70.1 (sd=7) and the highest age group with age less than 75 years old (73.56%).

The care received or not from people living with the elderly did not show any association with the sociodemographic variables, however, more than 92% of the elderly answered that they received help from people with whom they lived together, mainly women (95.03%), young people (95.41%), widows/widowers and married or with partners (96.83% and 95.31%, respectively), as seen in *table 1*.

Table 1. Frequency distribution and association for help received from people living and residing with the elderly and sociodemographic, health conditions and functionality variables. Várzea Grande (MT), Brazil, 2017

Variables	Help received or not from people living with the elderly (n=289)			Help received or not from people who do not live with the elderly								
				Children (n=315)			Siblings (n=308)			Another relatives and friends (n=347)		
	Yes n (%)	No n (%)	P-value[a]	Yes n (%)	No n (%)	P-value	Yes n (%)	No n (%)	P-value	Yes n (%)	No n (%)	P-value
Gender												
Male	105 (97.22)	3 (2.78)	0.5446[a]	80 (68.38)	37 (31.62)	0.0090[b]	21 (17.95)	96 (82.05)	0.0961[b]	58 (43.94)	74 (56.06)	0.0700[b]
Female	172 (95.03)	9 (4.97)		161 (81.31)	37 (18.69)		50 (26.18)	141 (73.82)		116 (53.95)	99 (46.05)	
Age												
60 to 74	208 (95.41)	10 (4.59)	0.7365[a]	176 (74.58)	60 (25.42)	0.2134[b]	50 (21.65)	181 (73.85)	0.3489[b]	121 (47.45)	134 (52.55)	0.1214[b]
75 or more	69 (97.18)	2 (2.82)		65 (82.28)	14 (17.72)		21 (27.27)	56 (72.73)		53 (57.61)	39 (42.39)	

Table 1. (cont.)

Marital status												
Married or with partner	183 (95.31)	9 (4.69)	0.8916[a]	148 (76.88)	45 (23.32)	0.1040[a]	31 (17.03)	151 (82.97)	0.0070[a]	95 (47.74)	104 (52.26)	0.0572[b]
Divorced, separated, judicially separated	16 (100)	0 (0)		6 (60)	4 (40)		8 (40)	12 (60)		17 (70.83)	7 (29.17)	
Single	17 (94.44)	1 (5.56)		17 (62.96)	10 (37.04)		5 (20)	20 (80)		10 (35.71)	18 (64.29)	
Widow/widower	61 (96.83)	2 (3.17)		70 (82.35)	15 (17.65)		27 (33.33)	54 (66.67)		52 (54.17)	44 (45.83)	
Family arrangement												
Live alone	-	-	*	34 (79.07)	9 (20.93)	0.8159[b]	13 (27.66)	34 (72.34)	0.5309[b]	29 (56.86)	22 (43.14)	0.3749[b]
Live with someone	-	-		207 (76.1)	65 (23.9)		58 (22.22)	203 (77.78)		145 (48.99)	151 (51.01)	
Health self-assessment												
Good/Very good	73 (93.59)	5 (6.41)	0.3211[a]	70 (77.78)	20 (22.22)	0.4550[b]	16 (18.6)	70 (81.4)	0.4543[b]	47 (48.45)	50 (51.55)	0.5812[b]
Regular	170 (97.14)	5 (2.86)		145 (73.6)	42 (21.32)		47 (25.41)	138 (74.59)		109 (52.15)	100 (47.85)	
Bad/Very bad	34 (94.44)	2 (5.56)		26 (68.42)	12 (31.58)		8 (21.62)	29 (78.38)		18 (43.9)	23 (56.1)	
Nº of diseases												
0 to 3	204 (95.77)	9 (4.23)	1[a]	179 (76.17)	56 (23.83)	0.9286[b]	52 (22.91)	175 (77.09)	1[b]	121 (46.72)	138 (53.28)	0.0388[b]
3 or more	73 (96.05)	3 (3.95)		62 (77.5)	18 (22.5)		19 (10.87)	62 (89.13)		53 (60.23)	35 (39.77)	
IADL												
Independent	105 (92.92)	8 (7.08)	0.0671[a]	106 (78.52)	29 (21.48)	0.4660[b]	26 (18.98)	111 (81.02)	0.1291[b]	73 (50)	73 (50)	0.9640[b]
Dependent	172 (97.73)	4 (2.27)		135 (75)	45 (25)		45 (26.32)	126 (73.68)		101 (50.25)	100 (49.75)	
BADL												
Independent	236 (95.93)	10 (4.07)	0.6951[a]	209 (76.56)	64 (23.44)	0.9581[b]	59 (22.26)	206 (77.74)	0.4150[b]	144 (48.32)	154 (51.68)	0.0940[b]
Dependent	41 (95.35)	2 (4.65)		32 (76.19)	10 (23.81)		12 (27.91)	31 (72.09)		30 (61.22)	19 (38.78)	

Source: Own elaboration.

* The variables are not associated, since they refer to people who live with the elderly.

[a] Fischer's Exact Test.

[b] Chi-square test.

Still in *table 1*, it is observed that the help received or not from people who did not live with the elderly showed association between children and gender (p=0.0090); marital status was associated with siblings (p=0.0070); number of diseases was related to the help of other relatives and friends (p=0.0388). Regarding the help received from children, the highest proportion was among women (81.31%); the help received from siblings and paid professionals was little mentioned among the elderly; and the request for help to other relatives and friends was greater among those who had three or more diseases.

It can be noted that the elderly who expected to be cared for by their spouses had a statistically significant association (p<0.001) with all sociodemographic variables analyzed, that is, gender, age, marital status and family arrangement. Likewise, among those who expected to be cared for by their daughters or daughters-in-law, there was also a significant association (p<0.001), except for the variable age. The expectation of care was centered within the family. Daughters or daughters-in-law were identified as the primary caretakers, except for the divorced, separated or judicially separated. Regarding gender, women had the expectation of, firstly, the care of daughters or daughters-in-law (81.78%), but they did not wait for the care of their husbands. Men also expected the care from wives and daughters

or daughters-in-law (71.76%); sons or sons-in-law appeared in third place as expectation of care for men and women (62.88% and 66.05%, respectively), as can be seen in *table 2*.

Table 2. Frequency distribution and association of care expectation with sociodemographic variables. Várzea Grande (MT), Brazil, 2017

Variables[a]	Yes n (%)	No n (%)	P-value[a]	Yes n (%)	No n (%)	P-value[a]	Yes n (%)	No n (%)	P-value[a]
	Spouse (n=345)			Daughter or daughter-in-law (n=345)			Son or son-in-law (n=347)		
Gender									
Male	94 (71.76)	37 (38.24)	<0.001	94 (71.76)	37 (28.24)	0.0291	83 (62.88)	49 (37.12)	0.5491
Female	88 (41.12)	126 (58.88)		175 (81.78)	39 (18.22)		142 (66.05)	73 (33.95)	
Age									
60 to 74	148 (58.27)	106 (41.73)	<0.001	195 (76.77)	59 (23.23)	0.4587	165 (64.71)	90 (35.29)	1
75 or more	34 (37.36)	57 (62.64)		74 (81.32)	17 (18.68)		60 (65.22)	32 (34.78)	
Marital status									
Married or with partner	163 (83.32)	35 (17.68)	<0.001	166 (83)	34 (17)	<0.001	141 (70.5)	59 (29.5)	<0.001
Divorced. separated. judicially separated	4 (16.67)	20 (83.33)		7 (29.17)	17 (70.83)		5 (20.83)	19 (79.17)	
Single	7 (25)	21 (75)		18 (64.29)	10 (35.71)		16 (57.14)	12 (42.86)	
Widow/widower	8 (8.42)	87 (91.58)		78 (83.87)	15 (16.13)		63 (66.32)	32 (33.68)	
Family arrangement									
Live alone	6 (12)	44 (88)	<0.001	33 (66)	17 (34)	0.0429	23 (46)	27 (54)	0.0043
Live with someone	176 (59.66)	119 (40.34)		236 (80)	59 (20)		202 (68.01)	95 (31.99)	
Variables[a]	**Yes n (%)**	**No n (%)**	**P-value[a]**	**Yes n (%)**	**No n (%)**	**P-value[a]**	**Yes**	**No n (%)**	**P-value[a]**
	Another relative (n=343)			Neighbor or friend (n=345)			Paid professional (n=345)		
Gender									
Male	63 (48.09)	68 (51.91)	0.6082	75 (56.82)	57 (43.18)	0.3940	27 (20.45)	105 (79.55)	0.1850
Female	108 (50.94)	104 (49.06)		111 (52.11)	102 (47.89)		57 (26.76)	156 (73.24)	
Age									
60 to 74	118 (46.83)	134 (53.17)	0.0810	129 (50.99)	124 (49.01)	0.0919	56 (22.05)	198 (77.95)	0.1282
75 or more	53 (47.75)	38 (52.25)		57 (61.96)	35 (38.04)		28 (30.77)	63 (69.23)	
Marital status									
Married or with partner	94 (47.47)	104 (52.53)	0.2601	99 (49.75)	100 (50.25)	0.2260	39 (19.6)	160 (80.4)	0.0020
Divorced. separated. judicially separated	16 (66.67)	8 (33.33)		12 (50)	12 (50)		3 (12.5)	21 (87.5)	
Single	12 (42.86)	16 (57.14)		17 (60.71)	11 (39.29)		6 (21.43)	22 (78.57)	
Widow/widower	49 (52.69)	44 (47.31)		58 (61.7)	36 (38.3)		36 (38.3)	58 (61.7)	
Family arrangement									
Live alone	24 (48)	26 (52)	0.8960	29 (58)	21 (42)	0.6558	16 (32)	34 (68)	0.2359
Live with someone	147 (50.17)	146 (49.83)		157 (53.22)	138 (46.78)		68 (23.05)	227 (76.95)	

Source: Own elaboration.

[a] Chi-square test.

The expectation of care regarding the health and functional conditions variables showed an association between the paid professional and the IADL (p=0.0270). Although there was no statistical significance, the daughter or daughter-in-law appears, with high frequency, as the first mention in the expectation of care among the elderly, as shown in *table 3*.

Table 3. Frequency distribution and association for care expectation with health conditions and functionality variables. Várzea Grande (MT), Brazil, 2017

Variables[a]	Yes n (%)	No n (%)	P-value[a]	Yes n (%)	No n (%)	P-value[a]	Yes n (%)	No n (%)	P-value[a]
	Spouse (n=345)			Daughter or daughter-in-law (n=345)			Son or son-in-law (n=347)		
Health self-assessment									
Good/Very good	50 (52.08)	46 (47.92)	0.7320	78 (80.41)	19 (19.59)	0.6430	64 (65.98)	33 (34.02)	0.8180
Regular	108 (51.92)	100 (48.08)		161 (77.78)	46 (22.22)		133 (63.64)	76 (36.36)	
Bad/Very bad	24 (58.54)	17 (41.46)		30 (73.17)	11 (26.83)		28 (68.29)	13 (31.71)	
Number of diseases									
0 to 2	133 (51.55)	125 (48.45)	0.5178	201 (78.21)	56 (21.79)	0.9728	166 (64.09)	93 (35.91)	0.7099
3 or more	49 (56.32)	38 (43.68)		68 (77.27)	20 (22.73)		59 (67.05)	29 (32.95)	
IADL									
Independent	69 (47.59)	76 (52.41)	0.1020	114 (79.17)	30 (20.83)	0.6500	97 (66.44)	49 (33.56)	0.5952
Dependent	113 (56.5)	87 (43.5)		155 (77.11)	46 (22.89)		128 (63.68)	73 (36.32)	
BADL									
Independent	157 (52.86)	140 (47.14)	0.9200	233 (78.72)	63 (21.28)	0.4120	195 (65.44)	103 (34.56)	0.5670
Dependent	25 (52.08)	23 (47.92)		36 (73.47)	13 (26.53)		30 (61.22)	19 (38.78)	
Variables[a]	**Yes n (%)**	**No n (%)**	**P-value[a]**	**Yes n (%)**	**No n (%)**	**P-value[a]**	**Yes n (%)**	**No n (%)**	**P-value[a]**
	Another relative (n=343)			Neighbor or friend (n=345)			Paid professional (n=345)		
Health self-assessment									
Good/Very good	44 (45.83)	52 (54.17)	0.3040	53 (55.21)	43 (44.79)	1.0000	28 (29.17)	68 (70.83)	0.2920
Regular	110 (53.14)	97 (46.86)		114 (54.81)	94 (45.19)		49 (23.56)	159 (76.44)	
Bad/Very bad	17 (42.5)	23 (57.5)		19 (46.34)	22 (53.66)		7 (17.07)	34 (82.93)	
Number of diseases									
0 to 2	122 (47.47)	135 (52.53)	0.1610	135 (53.33)	123 (47.67)	0.3712	60 (23.35)	197 (76.65)	0.5506
3 or more	49 (56.98)	37 (43.02)		51 (58.62)	36 (41.38)		24 (27.27)	64 (72.73)	
IADL									
Independent	77 (53.1)	68 (46.9)	0.3030	80 (55.17)	65 (44.83)	0.6890	44 (30.34)	101 (69.66)	0.0270
Dependent	94 (47.47)	104 (52.53)		106 (53)	94 (47)		40 (20)	160 (80)	
BADL									
Independent	143 (48.31)	153 (51.69)	0.1510	161 (54.03)	137 (45.97)	0.9150	69 (23.31)	227 (76.69)	0.2700
Dependent	28 (59.57)	19 (40.43)		25 (53.19)	22 (46.81)		15 (30.61)	34 (69.39)	

Source: Own elaboration.

[a] Chi-square test.

The analysis shows that the perceived support was positively evaluated by the interviewees, since most of the elderly answered 'always' to all questions, but there was only association between the 'have many people to talk to' response to the marital status (p=0.0260). The highest proportions were among widows/widowers (62.5%) and married or with partners (60.5%), as seen in *table 4*.

Table 4. Frequency distribution and association for perceived social support with sociodemographic variables. Várzea Grande (MT), Brazil, 2017

Variables		Never n (%)	Sometimes n (%)	Majority n (%)	Always n (%)	P-value(a)
Many people to talk to, when you feel alone (n=348)						
Gender	Male	3 (2.27)	37 (28.03)	20 (15.15)	72 (54.55)	0.0930
	Female	2 (0.93)	39 (18.06)	40 (18.52)	135 (62.5)	
Age	60 to 74	3 (1.17)	59 (23.05)	41 (16.02)	153 (59.76)	0.5773
	75 or more	2 (2.17)	17 (18.48)	19 (20.65)	54 (58.7)	
Marital status	Married or live with partner	0 (0)	45 (22.5)	34 (17)	121 (60.5)	0.0260
	Divorced, separated, judicially separated	1 (4.17)	10 (41.67)	3 (12.5)	10 (41.67)	
	Single	0 (0)	7 (25)	5 (17.86)	16 (57.14)	
	Widow/widower	4 (4.17)	14 (14.58)	18 (18.75)	60 (62.5)	
Family arrangement	Live alone	1 (1.96)	12 (23.53)	11 (21.57)	27 (52.94)	0.7360
	Live with someone	4 (1.34)	64 (21.55)	49 (16.5)	180 (60.61)	
Meet and talk to friends and relatives (n=346)						
Gender	Male	1 (0.77)	38 (29.23)	17 (13.08)	74 (56.92)	0.6829
	Female	3 (1.39)	55 (25.46)	37 (17.13)	121 (56.02)	
Age	60 to 74	4 (1.57)	71 (27.95)	42 (16.54)	137 (53.94)	0.4046
	75 or more	0 (0)	22 (23.91)	12 (13.04)	58 (63.05)	
Marital status	Married or live with partner	2 (1.01)	47 (23.74)	34 (17.17)	115 (58.08)	0.2037
	Divorced, separated, judicially separated	0 (0)	9 (37.5)	1 (4.17)	14 (58.33)	
	Single	2 (7.14)	9 (32.14)	3 (10.71)	14 (50)	
	Widow/widower	0 (0)	28 (29.17)	16 (16.67)	52 (54.17)	
Family arrangement	Live alone	0 (0)	20 (39.22)	7 (13.73)	24 (47.05)	0.2063
	Live with someone	4 (1.36)	73 (24.75)	47 (15.93)	171 (57.96)	
Ease in finding people to help in the tasks (n=345)						
Gender	Male	3 (2.33)	29 (22.48)	20 (15.5)	77 (59.69)	0.6937
	Female	7 (3.24)	55 (25.46)	25 (11.57)	129 (59.72)	
Age	60 to 74	5 (1.98)	63 (24.9)	32 (12.65)	153 (60.47)	0.375
	75 or more	5 (5.43)	21 (22.83)	13 (14.13)	53 (57.61)	
Marital status	Married or live with partner	3 (1.52)	50 (25.25)	23 (11.62)	122 (61.62)	0.0604
	Divorced, separated, judicially separated	3 (12.5)	6 (25)	6 (25)	9 (37.5)	
	Single	0 (0)	9 (33.33)	4 (14.81)	14 (51.85)	
	Widow/widower	4 (4.17)	19 (19.79)	12 (12.5)	61 (63.54)	

Table 4. (cont.)

Family arrangement	Live alone	3 (5.88)	13 (25.49)	8 (15.69)	27 (52.94)	0.3722
	Live with someone	7 (2.38)	71 (24.15)	37 (12.59)	179 (60.88)	
Count on someone for suggestion on some problem (n=346)						
Gender	Male	5 (3.79)	30 (22.73)	23(17.42)	74 (56.06)	0.2310
	Female	6 (2.8)	45 (21.03)	23 (10.75)	140 (65.42)	
Age	60 to 74	8 (3.14)	49 (19.21)	35 (13.73)	163 (63.92)	0.3148
	75 or more	3 (3.3)	26 (28.57)	11 (12.09)	51 (56.04)	
Marital status	Married or live with partner	4 (2)	44 (22)	30 (15)	122 (61)	0.1829
	Divorced, separated, judicially separated.	2 (8.33)	6 (25)	5 (20.83)	11 (45.83)	
	Single	2 (7.14)	3 (10.71)	2 (7.14)	21 (75)	
	Widow/widower	3 (3.19)	22 (23.4)	9 (9.57)	60 (63.83)	
Family arrangement	Live alone	2 (4)	11 (22)	6 (12)	31 (62)	0.9499
	Live with someone	9 (3.04)	64 (21.62)	40 (13.51)	183 (61.83)	
Someone you absolutely trust (n=346)						
Gender	Male	5 (3.85)	18 (13.85)	15 (11.54)	92 (70.77)	0.4950
	Female	8 (3.7)	35 (16.2)	15 (6.94)	158 (73.15)	
Age	60 to 74	10 (3.94)	41 (16.14)	23 (9.06)	180 (70.86)	0.8198
	75 or more	3 (3.26)	12 (13.04)	7 (7.61)	70 (76.09)	
Marital status	Married or live with partner	4 (2.02)	28 (14.14)	19 (9.6)	147 (74.24)	0.1086
	Divorced, separated, judicially separated	2 (8.33)	4 (16.67)	2 (8.33)	16 (66.67)	
	Single	4 (14.29)	7 (25)	1 (3.57)	16 (57.14)	
	Widow/widower	3 (3.13)	14 (14.58)	8 (8.33)	71 (73.96)	
Family arrangement	Live alone	3 (5.88)	11 (21.57)	6 (11.76)	31 (60.79)	0.1828
	Live with someone	10 (3.39)	42 (14.24)	24 (8.14)	219 (4.23)	

Source: Own elaboration.

[a]Fischer's Exact Test.

In the association of perceived support and health and functional conditions there was a significant association between the answer 'it is easy to find people who can help you in your tasks if you become ill' with health self-assessment (p=0.0418) and number of diseases (p=0.0207); 'have someone to turn to when you need a suggestion on how deal with some problem' had an association with health self-assessment (p=0.0342). Although there was no significance among the variables, 'have at least one person in whose opinion you absolutely trust' showed the highest proportions among the elderly aged 75 years or older (76.09%) and who had three or more diseases (76,14 %), as shown in *table 5*.

Table 5. Frequency distribution and association for social support perceived with health conditions and functionality variables. Várzea Grande (MT), Brazil, 2017

Varibles		Never n (%)	Sometimes n (%)	Majority n (%)	Never n (%)	P-value(a)
Many people to talk to, when you feel alone (n=348)						
Health self-assessment	Good/Very good	1 (1.03)	21 (21.65)	18 (18.56)	57 (58.76)	0.7791
	Regular	4 (1.9)	43 (20.48)	38 (18.1)	125 (59.52)	
	Bad/Very bad	0 (0)	12 (29.27)	4 (9.76)	25 (60.98)	
Number of diseases	0 to 2	4 (1.54)	60 (23.17)	46 (17.76)	149 (57.53)	0.6564
	3 or more	1 (1.12)	16 (17.98)	14 (15.73)	58 (65.17)	
IADL	Independent	2 (1.36)	27 (18.37)	28 (19.05)	90 (61.22)	0.5440
	Dependent	3 (1.49)	49 (24.38)	32 (15.92)	117 (34.69)	
BADL	Independent	4 (1.34)	65 (21.74)	50 (16.72)	180 (60.2)	0.7310
	Dependent	1 (2.04)	11 (22.45)	10 (20.41)	27 (55.1)	
Meet and talk to friends and relatives (n=346)						
Health self-assessment	Good/Very good	2 (2.08)	18 (18.75)	18 (18.75)	58 (60.42)	0.3122
	Regular	2 (0.96)	60 (28.71)	31 (14.83)	116 (55.5)	
	Bad/Very bad	0 (0)	15 (36.59)	5 (12.2)	21 (51.22)	
Number of diseases	0 to 2	3 (1.17)	73 (28.4)	46 (17.9)	135 (52.53)	0.0776
	3 or more	1 (1.12)	20 (22.47)	8 (8.99)	60 (67.42)	
IADL	Independent	2 (1.36)	32 (21.77)	25 (17.01)	88 (59.86)	0.3057
	Dependent	2 (1.01)	61 (30.65)	29 (14.57)	107 (53.77)	
BADL	Independent	3 (1.01)	76 (25.59)	50 (16.84)	168 (56.57)	0.2100
	Dependent	1 (2.04)	17 (34.69)	4 (8.16)	27 (55.1)	
Ease in finding people to help in the tasks (n=345)						
Health self-assessment	Good/Very good	1 (1.03)	14 (14.43)	17 (17.53)	65 (67.01)	0.0418
	Regular	8 (3.83)	59 (28.23)	26 (12.44)	116 (55.5)	
	Bad/Very bad	1 (2.56)	11 (28.21)	2 (5.13)	25 (64.1)	
Number of diseases	0 to 2	6 (2.33)	71 (27.52)	37 (14.34)	144 (55.81)	0.0207
	3 or more	4 (4.6)	13 (14.94)	8 (9.2)	62 (71.26)	
IADL	Independent	4 (2.72)	34 (23.13)	19 (12.93)	90 (61.22)	0.9658
	Dependent	6 (3.03)	50 (25.25)	26 (13.13)	116 (58.59)	
BADL	Independent	9 (3.03)	71 (23.91)	42 (14.14)	175 (58.92)	0.4923
	Dependent	1 (2.08)	13 (27.08)	3 (6.25)	31 (64.58)	
Count on someone for suggestion on some problem (n=346)						
Health self-assessment	Good/Very good	0 (0)	15 (15.79)	14 (14.74)	66 (69.47)	0.0342
	Regular	7 (3.33)	52 (24.76)	29 (13.81)	122 (58.1)	
	Bad/Very bad	4 (9.76)	8 (19.51)	3 (7.32)	26 (63.41)	
Number of diseases	0 to 2	7 (2.71)	61 (23.64)	34 (13.18)	156 (60.47)	0.3849
	3 or more	4 (4.55)	14 (15.91)	12 (13.64)	58 (65.9)	

Table 5. (cont.)

IADL	Independent	5 (3.45)	28 (19.31)	18 (12.41)	94 (64.83)	0.7437
	Dependent	6 (2.99)	47 (23.38)	28 (13.93)	120 (59.7)	
BADL	Independent	8 (2.68)	61 (20.47)	41 (13.76)	188 (63.09)	0.2259
	Dependent	3 (6.25)	14 (29.17)	5 (10.42)	26 (54.17)	
Someone you absolutely trust (n=346)						
Health self-assessment	Good/Very good	2 (2.08)	13 (13.54)	12 (12.5)	69 (71.88)	0.3172
	Regular	7 (3.35)	35 (16.75)	16 (7.66)	151 (72.25)	
	Bad/Very bad	4 (9.76)	5 (12.2)	2 (4.88)	30 (73.17)	
Number of diseases	0 to 2	10 (3.88)	42 (16.28)	23 (8.91)	183 (70.93)	0.8420
	3 or more	3 (3.41)	11 (12.5)	7 (7.95)	67 (76.14)	
IADL	Independent	5 (3.45)	20 (13.79)	12 (8.28)	108 (74.48)	0.8918
	Dependent	8 (3.98)	33 (16.42)	18 (8.96)	142 (70.65)	
BADL	Independent	10 (3.37)	41 (13.8)	28 (9.43)	218 (73.4)	0.1088
	Dependent	3 (6.12)	12 (24.49)	2 (4.08)	32 (65.31)	

Fonte: Elaboração própria.

[a]Teste Exato de Fischer.

Discussion

In this study, the prevalence of elderly women was observed. Most of them live with their spouse and have low schooling. When it comes to support, the help received from family members, whether they cohabit or not, prevails. The family is the main provider of care, especially, by women, whether daughters, daughters-in-law or wives. The study, therefore, corroborates other researches regarding the characteristics of the elderly, in which the majority is composed of women[20]; married individuals or living with companions, followed by elderly widows/widowers[8,21-24]; with education of up to four years of study[20]; and low income (up to two minimum wages)[8,21,22,24].

Both inside and outside home, the results show that family members are the main providers of help for the elderly, especially children. It is important to highlight that, among the respondents, more than 60% are dependent on IADL. Elderly people who receive help from the people they live with are mostly women, elderly people aged 60 to 74, widows/widowers and married or with partners. Data from Sabe study shows that the chances of low aid frequency are higher among men and women who live alone when associated with the family arrangement; single men and widowers, if associated with marital status; and, for both genders, these chances are greater for the unmarried[25].

It is observed that, with respect to expectation of care, comparing the family members, the daughters or daughters-in-law are mentioned first, followed by children or sons-in-law[8]. Among men, the expectation of being cared for by their wives predominates; and, among women, by daughters and daughters-in-law[26,27]. Married and younger men are the ones who most expect to be looked after by their wives. Women, older elderly and widowers expect more care from daughters or daughters-in-law. Regarding age, gender and care by the spouse, especially among men, other studies show that, compared to women, they tend to receive less social support and

are more at risk of not getting this support adequately in the informal network[16].

Family caregivers are predominantly female[28-31] and live in the homes of the elderly[29,31]. According to Liu[28], the provision of care, support and relatedness is centered on women, who are held accountable for the interdependence and facilitation of intergenerational ties in family contexts. A study carried out in rural areas of China shows that daughters, in the absence of brothers, are providing emotional and instrumental support for parents of old age, noting that this type of work is not valued and compensated[28]. A similar result occurs in the study carried out in Pantanal of Mato Grosso[32]. The probability of providing care is greater for daughters than for their sons, evidencing the presence of women in the care function, and, many times, this centrality leads to the overburden of one person[8,21,26,28,30,33-35].

It is known that the residences are composed of new family arrangements, and that it can provide the division of the task of caring for the elderly. This helps to reduce hospitalizations and isolation of the elderly at home, as well as in long-stay institutions[27,31]. However, it is known that such a task can be exhausting and solitary, since, often, as has already been said, it is performed by a single person, without any preparation or guidance. Even, the caregiver of the elderly may turn out to be another elderly person, and all of these factors may increase the likelihood of risks during the journey[27,31].

The paid professional is little mentioned, considering the socioeconomic characteristics of the participants. It is notorious that elderly people with fewer resources and health problems are conditioned to dependence on smaller and closer networks[23,36]. Elderly people in a disadvantaged socioeconomic situation reported a poorer social network[16] and a greater probability of receiving informal care[37], that is, mainly provided by the relatives with whom they coexist. Children are the greatest providers of help when compared to friends, neighbors and colleagues[14,31], which corroborates the data of this research.

In general, the data show that the elderly people have positive views about their social support network. The questions regarding this support have more emphasis on social and emotional aspects, and most of the elderly responded 'always' to all questions, considering that they have someone to rely on, from whom to receive emotional or affective, instrumental and informative support[7]. Some authors point out that support for care is present in the majority of the elderly and is offered, in most cases, by family members, in this hierarchical order: spouse, children and friends[11,21], which help in domestic activities, personal care, financial support, company and visits[21,32].

This study shows that social support perceived positively is among women; young adults; those who live with someone; who are married or have a partner; who are independent for IADL and BADL; and those who have three or more diseases. Women establish more social relationships, have a more socially oriented life, which provides many sources of support and help, while men tend to trust their wives more[16]. The Sabe study shows that, in relation to the diversity and frequency of contacts, single men and women are more likely to have less constancy in these contacts, and that the long-living women (75 years or more) are less likely to present great variety of contacts[25].

The act of fully trusting someone is positively emphasized, especially among those considered to be the most vulnerable, that is, with old age, lower schooling and income, with bad/very bad health ratings and who have three or more diseases. Other authors point out that, in the more advanced ages, the social network becomes narrower, focused on the family, and has a greater geographical proximity[23]. These elderly people tend to be more selective about time and emotional investments, resulting in a lower frequency of contacts, which

are more restricted to relatives[23,35]. Long-lived individuals tend to be more isolated and less socially supported, as individuals under the age of 70 – mainly between 60 and 64 – require more support, and those aged 80 and over are prone to the reduction of social relations, as a consequence of health problems, functional limitations and retirements[16].

The filial responsibility is defined as social or cultural norms regarding the care for parents in the old age, and can be considered as individual attitude or belief, that is, there is the obligatoriness of the caring behavior[27,32,38]. Many dependent elders, due to some disease, do not have a formal care network and, under such conditions, the family is the main source of support and assistance[4,6,11,26,32,39].

Social support is multivariate, and should be considered in health care as a whole, and not exclusively in relation to the disease, since even when very restricted in the life of the elderly, it has multiplier potential, favors integration and well-being[5]. In this sense, it is necessary for health professionals to recognize the family caregiver as the main provider of care and to involve them in their home care plans[31].

The limitation of this study can be considered in the profile of the elderly, who, although they come from different regions, they present similar characteristics, which precludes greater statistical significance about perceived and received social support. In general terms, it can be said that the family has manifested itself as the main provider of care and social support. Socioeconomic vulnerability, old age, illnesses and disabilities, together or by themselves, can lead to a restriction of the support network of the elderly.

In old age, although there is a greater dependency on a network of backing and support, it tends to narrow down, limiting itself to the family nucleus. Consequently, it is important that there is support for family caregivers as well, and as a care strategy, it is suggested that caregiver groups be set up in the BHU, seeking to instrumentalize these individuals for the care of the elderly and for self-care. This is to prioritize and be attentive to the sickest, functionally compromised elderly, who live alone or live together with other elderly people, as well as older caregivers, with health problems already in place.

Conclusions

The study shows that the elderly people always expect to find, in their families, backing and support, when necessary, especially in their children, inside or outside home, having daughters or daughters-in-law as their primary caregivers, and wives are seen as potential caregivers. The most vulnerable elderly people show a positive evaluation of their social support networks.

There is a centrality in the family, which, often, does not provide sufficient or adequate care for the sick and disabled elderly, and it is suggested, thus, the need for guidance and support from the formal support network. There is no significance in the study for the backing and support of friends and neighbors in expectation of the care and support received, but it is known that the existence of a consistent network, composed of such persons, is important in the life of humans, instrumentally or materially, and, on many occasions, as emotional support in times of anguish and loneliness.

The continuation of research regarding support and social support in old age is suggested, and it is hoped that this study will, somehow, encourage the search for strategies and the implementation of programs of care and support for the elderly and their caregivers. The absence or precariousness of care for the elderly is strongly based on discussions of social rights and legal actions. In this sense, it is fundamental that there is a shared responsibility between the organs of the public power and the civil society, in order to move the effectiveness of the policies of care to the

elderly, in a more comprehensive way and with more quality.

Collaborators

Sant 'Ana LAJ (0000-0002-1377-3112)* participated substantially in the design, planning, collection, analysis and interpretation of the data, elaboration of the draft and critical review of the content. D 'Elboux MJ (0000-0002-7973-3439)* participated substantially in the design, planning, analysis and interpretation of the data, participated significantly in the critical review of the content and participated in the approval of the final version of the manuscript. ■

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