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REFACS

Conceptions of the elderly on (inter) national policies on human aging

Concepções de Idosos sobre as Políticas (Inter) Nacionais do Envelhecimento Humano

Concepciones de Ancianos acerca de las Políticas (Inter) Nacionales de Envejecimiento Humano

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This is an exploratory study with a qualitative approach, carried out in 2015 and aimed to analyze the perceptions of the elderly about human aging in the light of (inter)national political outlines. We investigated 93 elderly people assigned to Primary Care, with content categorized according to the (inter)national policies of human aging. Characterization data were collected and individual interviews were conducted according to guiding questions. The content analysis was supported by the NVivo Pro11® Software, with a theoretical density (Pearson ≥0.7). The speeches reiterated the pillars (participation, health and safety) and the determinants of health (social and health service, behavioral, personal, physical, social and economic environment). Three categories emerged: 1) Engagement, socialization and intergenerational coexistence; 2) Health, well-being and support networks and 3) Social security, adaptation and quality of life. Reified knowledge was evidenced, even if implicitly in the participants' speeches regarding all pillars, determinants, dimensions and (inter)national political axes.
Descriptors: Health Policy; Aging; Aged; Primary Health Care.

Este é um estudo exploratório com abordagem qualitativa, realizado em 2015, que teve como objetivo analisar as percepções de idosos sobre o envelhecimento humano à luz dos contornos políticos (inter)nacionais. Pesquisou-se 93 idosos adstritos à Atenção Básica, com conteúdos categorizados segundo as políticas (inter)nacionais do envelhecimento humano. Coletaram-se dados de caracterização e realizaram-se entrevistas individuais segundo questões norteadoras. A análise de conteúdo apoiou-se no *Software NVivo Pro11*®, sendo o adensamento teórico (Pearson ≥0,7). Os discursos reiteraram os pilares (participação, saúde e segurança) e os determinantes de saúde (serviço social e de saúde, comportamentais, pessoais, ambiente físico, sociais e econômicos). Emergiram três categorias: 1) Engajamento, socialização e convivência intergeracional; 2) Saúde, bem-estar e redes de apoio e 3) Seguridade social, adaptação e qualidade de vida. Evidenciou-se o conhecimento reificado, mesmo que de forma implícita, nos discursos dos participantes referente a todos os pilares, determinantes, dimensões e eixos políticos (inter)nacionais.
Descritores: Política de saúde; Envelhecimento; Idoso; Atenção Primária à Saúde.

Este es un estudio exploratorio con un enfoque cualitativo, realizado en 2015, que tuvo por objeto analizar las percepciones de los ancianos acerca del envejecimiento humano con respecto a los contornos políticos (inter)nacionales. Se investigó 93 ancianos asignados a la Atención Básica, con contenidos clasificados según las políticas (inter)nacionales de envejecimiento humano. Se reunieron datos de caracterización y se realizaron entrevistas individuales de acuerdo con las preguntas orientadoras. El análisis del contenido se basó en el *software NVivo Pro11*® con la consolidación teórica (Pearson ≥0,7). En los discursos se reiteraron los pilares (participación, salud y seguridad) y los determinantes de la salud (servicio social y de salud, conductuales, personales, entorno físico, sociales y económicos). Surgieron tres categorías: 1) Compromiso, socialización y coexistencia intergeneracional; 2) Salud, bienestar y redes de apoyo y 3) Seguridad social, adaptación y calidad de vida. El conocimiento cosificado, aunque implícito, se hizo evidente en los discursos de los participantes en relación con todos los pilares, determinantes, dimensiones y ejes políticos (inter)nacionales
Descriptores: Política de Salud; Envejecimiento; Anciano; Atención Primaria de Salud.

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INTRODUCTION

Human aging can be conceived of as a multifaceted sociovital process that develops over the course of life and in a sequential manner[1,2]. As a vital stage, it is configured as a slow, dynamic, progressive and inevitable process, which encompasses a set of morphological, physiological, biochemical and psychological changes, capable of determining progressive loss of the elderly person's ability to adapt to the social context[2,3]; in addition to the appearance of vulnerabilities due to the incidence of pathological processes associated with geriatric syndromes[4,5].

The aging process starts right after the development and stabilization phases, it usually becomes noticeable after structural and functional changes, whose detection shows its first features at the end of the third decade of life[1,2]. This characterization receives intrinsic influences, such as the individual genetic constitution responsible for longevity and extrinsic factors consistent with environmental exposures, which cause diverse and heterogeneous conditions[4,5].

The decline in body functions occurs in a way linked to the progression of aging and has variable rhythms between organs and differently between people of the same age. This subjectivity can be justified by the different living and working conditions to which each person has been exposed over the years, being circumscribed in different economic, political, social and cultural contexts[4,5].

Scientific investigations foster the need to experience the aging process as a natural stage of the life cycle as well as any other, marked by countless virtues and challenges. The (inter)national paradigm involves the conceptual detachment of aging as being equivalent to disease, inactivity or involution. Thus, different policies have been outlined worldwide[6,8].

In this context, the active aging policy proposed in 2002 by the World Health Organization (WHO), which was translated as Brazilian policy in 2005, emphasizes that aging well is a process that must be facilitated by specific public, social and health policies in each stage of the human life cycle[7-8].

Theoretical perspectives of “successful aging” include the benefits of a healthy lifestyle, with active and socially engaged aging. In this conception, successful aging is associated with ideological changes that do not consider this phase of life to be synonymous with loss, disease, inactivity or something contrary to human development[9,10].

In addition to the idealized conceptions of active and successful aging, in 2012, there was the initiative of idealizing a “society for all ages”, defined as intergenerational solidarity, which together can be considered guiding questions for the creation of innovative policies capable of to respond to the different emerging demands regarding (inter)national human aging[6].

The Brazilian initiatives regarding aging are the National Health Policy for the Elderly (NHPE)[11], the Statute for the Elderly[12] and the Elderly Health Care Booklet, in addition to the recognition and adoption of international policies[13,14].

With regard to the knowledge and applicability of the PNPSI, a study[15] carried out in the state of Santa Catarina that deals with the actions developed in the context of primary care showed that all participants thought they knew the policy, all had somehow had contact with the ordinance that institutes it, however, presented difficulties related to the lack of planning based on the NHPE guidelines to establish resolutive and educational actions for the health of the elderly population and the limit on social control that affects the health of the elderly.

In this context, this investigation is justified and the importance of the involvement of health professionals, including nurses, in the understanding of the peculiarities involved in the aging process and its political dimensions, conceived from the elderly people they care for, is emphasized. .

The approaches/interventions of health professionals must cover the different demands presented due to the challenges of human aging and contribute to the construction of active,

successful aging and intergenerational solidarity. Thus, this study aims to analyze the perceptions of the elderly about human aging in the light of (inter)national political outlines.

METHOD

Exploratory research, with a qualitative approach, which used the (inter)national policies of the human aging process[6-10] as a theoretical foundation capable of justifying the perception of the elderly about the aging process.

People aged ≥65 years with a compatible cognition level were eligible for the approach required by the in-depth interview. Survey sampling was used as the criterion of intercession between the BUS (Basic Health Unit) territoriality and the census area according to the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística - IBGE*).

The data collection instrument was structured in: 1) Sociodemographic characterization; 2) In-depth individual interview with audio recording based on the guiding questions and 3) Field diary. The 11 thematic axes of the interview were: 1) Conception of when and how the aging process occurs; 2) Incorporation of the cultural identity of being an elderly person; 3) Cultural definition of the role of the elderly in society; 4) Valuing the knowledge and experience of the elderly; 5) The role of the elderly in the community; 6) Impact of age on social and family life; 7) Positioning and adherence to policies, programs and services; 8) Participation or integration in political, social or religious representations; 9) Use of the (in)formal health network; 10) Adherence to existing services and 11) Insertion in religious practices.

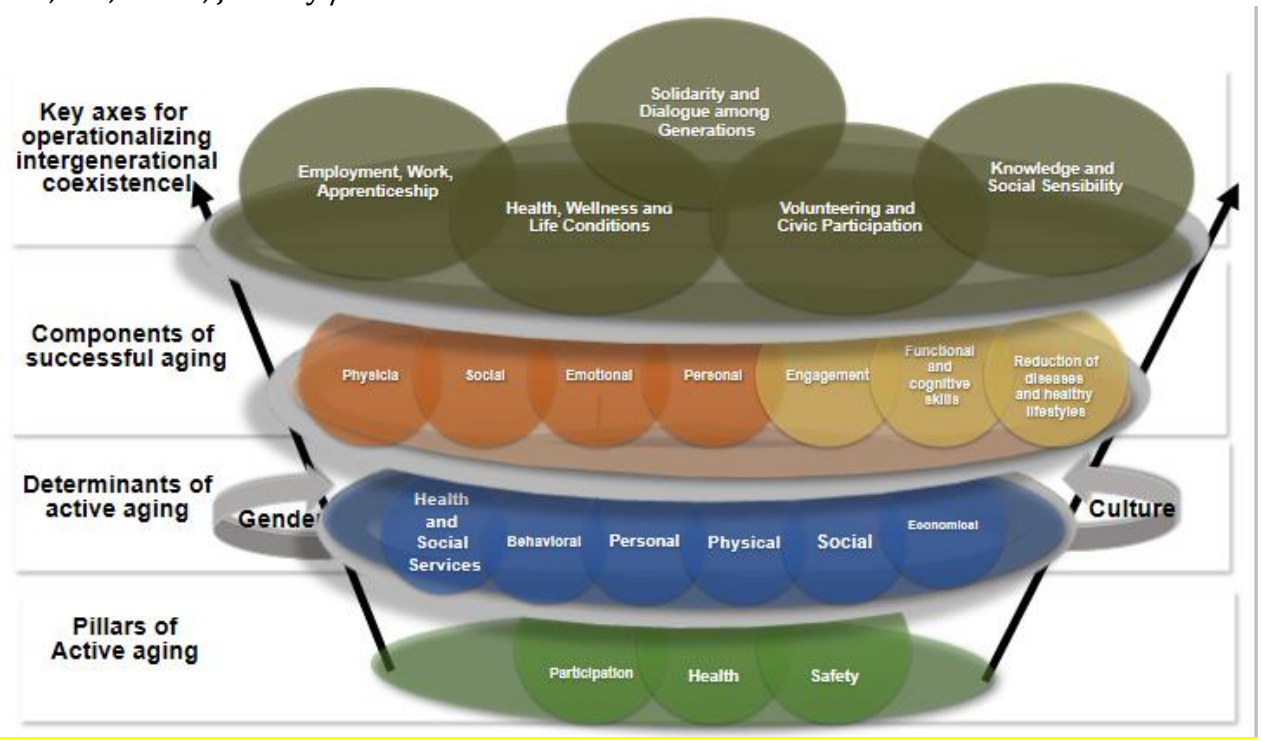
The ambience and the recruitment of potential participants were carried out through an individual approach and invitation at home with the collection of the signature of the Free and Informed Consent Form (ICF). In the second moment, individual in-depth interviews were conducted, with audio recording, to apprehend the conceptions of policies on aging.

Data collection was carried out by a single researcher, aiming to reduce approach bias and make time compatible with the availability of the participants; having been the data collected in January of 2015, with an estimated duration of the interview in 1 hour.

The analysis of the participants' understanding of the human aging process in the light of (inter)national policies was based on the schematic structure of the political axes. The 2002 Active Aging Policy is based on the pillars of participation, health and safety that are based on the eight determinants of the aging process, which are close to the perspective of the seven components of successful aging which have been corroborated. by the five key axes for the operationalization of the intergenerational coexistence of the elderly proposed in the European year of active, successful aging and solidarity between generations[6-10] (Figure 1). It is also worth mentioning that the internationalization of policies that portray the human aging process were gradually and sequentially translated, validated and incorporated nationally as occurred in Brazil (13-15).

Three software were used for data treatment and analysis, namely: sociodemographic data consolidated in the Statistical Package for the Social Sciences (SPSS) version 24; the interviews were transcribed in Microsoft® Office Word® 2016 and inserted and treated in NVivo Pro 11®.

Figure 1. Representative scheme of the axes of (inter) national human aging policies. Juiz de Fora, MG, Brazil, January / 2015.



Source: adaptation of the theoretical references of human aging policies[6-10].

To understand the data, content analysis was performed according to the steps: pre-analysis, exploration of the material or coding and treatment of the results obtained/interpretation[16]. The criteria for creating the units of meaning were: the similarity of the contents and theoretical densification to obtain Pearson's coefficient with values ≥0.70[17].

Ethical and legal requirements were met in research involving human beings, according to (inter)national legislation. This investigation comes from a matrix research, entitled "*Physical capacity, incontinence and determinants of the aging process in people over 65 years old*", approved by the Research Ethics Committee (substantiated opinion no. 341,116, of 11/07/2013). To ensure anonymity, participants were identified by alphanumeric codes, the letter P being followed by 2 digits.

RESULTS

The sociodemographic characterization of the participants is shown in Table 1.

Table 1. Sociodemographic characterization of the 93 participants. Juiz de Fora, MG, Brazil, January/2015.

Gender	n	%	Md±DP	Age group	n	%	Md±DP
Female	**58**	**62.4**		65 - 70	19	20.43	
Male	35	37.6		70 - 75	**34**	**36.55**	
Subtotal	**93**	**100.0**		75 - 80	23	24.75	72±6,486 Min=65 Max=96
				80 - 85	11	11.82	
Education level	**N**	**%**		85 - 90	4	4.30	
0	26	27.95		≥90 -	2	2.15	
1I--- 5	**45**	**48.38**	2±2,918	**Subtotal**	**93**	**100.0**	
5I --- 9	11	11.82	Min=0 and				
9I --- 13	10	10.77	Mx=15	**Marital status**			
≥13	1	1.08		Married	**50**	**53.76**	
Subtotal	**93**	**100.0**		Widower	30	32.25	
				Single	7	7.55	
Income (minimum wages)				Divorced	5	5.37	
0	1	1,1		Separated	1	1.07	
1	**67**	**72,0**		**Subtotal**	**93**	**100,0**	
1,5	4	4,2					
2	16	17,2		**N° filhos**			
3	3	3,3		0	8	8.60	
4	1	1,1		1 - 5	**39**	**41.95**	4±4,597
5	1	1,1		5 - 10	36	38.70	Min=0 Max=21
Subtotal	**93**	**100,0**		10 - 15	8	8.60	
				≥ 15	2	2.15	
				Subtotal	**93**	**100.0**	
Self-declared skin color	**n**	**%**	**Md±DP**	**Time (years) of retirement**	**n**	**%**	**Md±DP**
Brown	**48**	**51.6**		0	22	23.65	9,50±8,659
White	27	29.0		1 - 5	4	4.30	Min=0 and
Black	18	19.4		5 - 10	22	23.65	Mx=37
Subtotal	**93**	**100.0**		10 - 15	**23**	**24.73**	
				15 - 20	10	10.75	
Occupation	**n**	**%**		20 - 30	11	11.82	
No income	5	5.37		30 - 40	1	1.07	
Retired	**81**	**87.09**		**Subtotal**	**93**	**100.0**	
Pensioners	5	5.37					
Has a job	2	2.15					
Subtotal	**93**	**100.0**					

Regarding the professions of the participants during the productive phase of their lives, they are shown in Table 2.

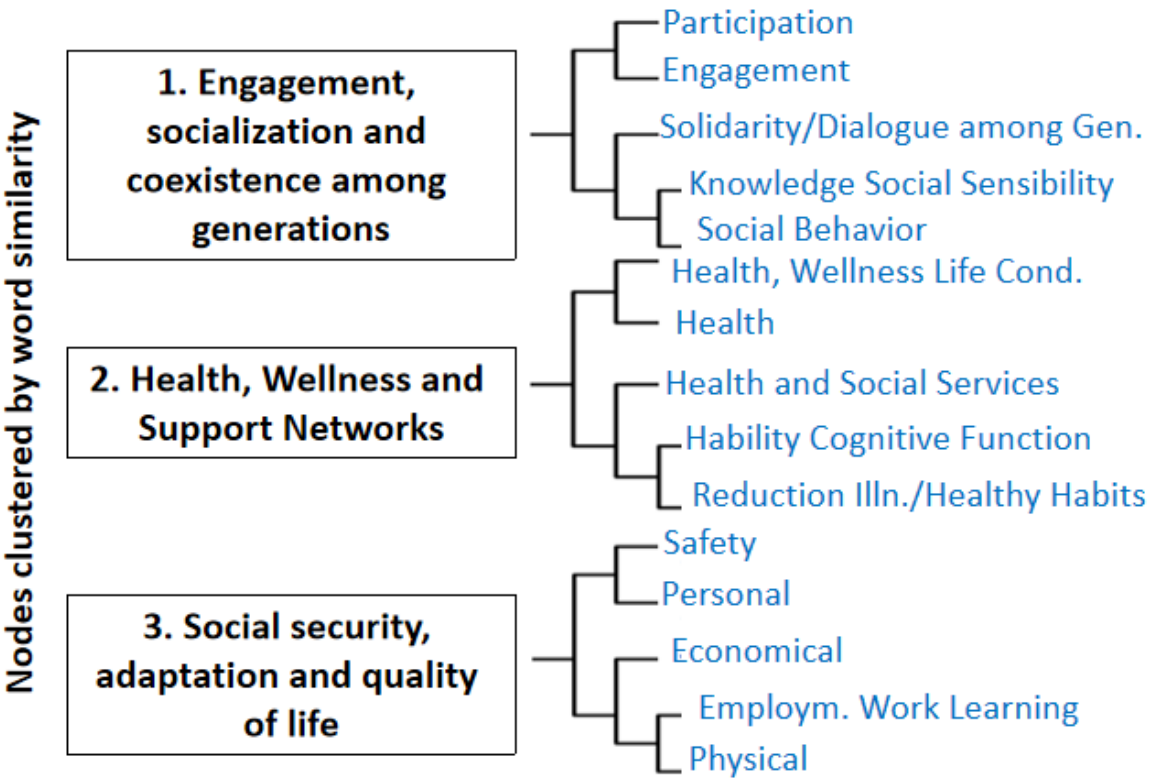
Table 2. Professional areas of the participants. Juiz de Fora, MG, Brazil, January / 2015.

Profession	N	%
Domestic services (domestic, cleaning agent, cleaning lady, laundress and general services)	**38**	**40.87**
Civil construction (bricklayer, carpenter, bricklayer, decorator, cabinetmaker and master of works)	**20**	**21.50**
Building/condominium maintenance services (receptionist, porter, elevator, watchman)	9	9.68
Food services (cook and waiter)	9	9.68
Technical level activity (nursing, laboratory and caregivers for the elderly)	6	6.45
Seamstress/weaver	4	4.30
Driver	2	2.15
Mechanic/panel beater	2	2.15
Gardener/farmer	2	2.15
Salesperson	1	1.07
Total	**93**	**100.0**

Three categories of data analysis were obtained, namely:
1) Engagement, socialization and intergenerational coexistence;
2) Health, well-being and support networks; and,
3) Social security, adaptation and quality of life.

Figure 2 shows the dendrogram with a correlation force scheme between them.

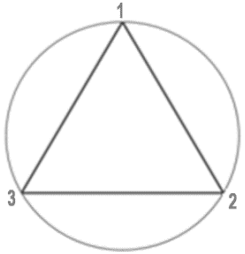
Figure 2. Dendogram - identified analysis categories and correlation forces scheme (N = 93). Juiz de Fora, January / 2015.

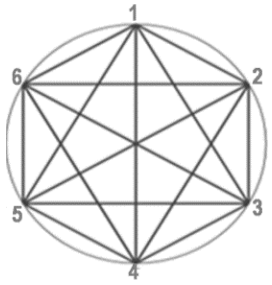


Source: Content extracted from the Nvivo Pro 11® program.

It appears in Table 1, the speeches of the participants according to adopted references, subject code, number of fragments extracted from each speech and scheme of correlation forces between the categories expressed by the circle graph.

Chart 1. Representative scheme of content analysis and correlation forces between categories expressed by the circle graph. Juiz de Fora, MG, Brazil, January / 2015.

Reference for the Active Aging Policy, Analysis units / Record Units (*) and Circle graph.		Illustrative lines of content analysis
Pillars 	1. Participação[6-8] 88/981	**Social**: *The difficulty in society is that sometimes they do not hire or send people away just because of their age.* P12 **Economics**: *I taught my daughters like this: Are we going to buy something next month? [...] Pay what is already spent, because what will enter won't be spent at the moment.* P12 **Cultural**: *Knowledge and life experience are very great and we should try to pass them on to family members.* P14 **Spiritual**: *I work in the church and pastoral.* P30 **Social component**: *I studied very little, because I lived in the countryside. So! When my father was a little old, he used to help out in the fields. He said that working in the fields was better than studying and learning things you shouldn't.* P13 **Engagement:** *Many people in their 70s, 80s, 90s are living life, exercising and moving on.* P89 **Intergenerational relations**: *I live a lot with people. Older people, younger than me. I live well with everyone.* P12 **Volunteering**: *Working, sometimes, even as a volunteer, which is very important and helps to not feel invalid.* P39 **Social awareness**: *I need help. I need to operate, I need medicine, I need to take care of my health, but I have no money for anything.* P43
	2. Saúde[6-8] 88/576	**Behavioral and environmental risks**: *These are things that you can not allow too much to accumulate, if you let the disease accumulate, then it becomes more difficult. You have to act against the disease, if it is treated ...* P73 **Functional decline**: *The person, after 50 years old, already has to manage a little, because the organism is no longer the same.* P51 **Protective factors**: *My son who lives with me has a lot of care. He is very affectionate!* P79 **Functional and cognitive skills**: *The elderly person must want to look for a job, do gymnastics, a walk, teach younger people, they just can't stand still.* P51 **Reduction of diseases and healthy lifestyles**: *When I feel bad, I take medicine, make some tea, go to the doctor.* P39 **Health, well-being and living conditions**: *Good living conditions are the person having more opportunities to study and work in lighter services; because the elderly will not be able to sacrifice much*. P11
	3. Segurança[6-8] 87/426	**Social**: *My kids fight me a lot. This son is good when he is healthy, because when he is on drugs he is complicated! The other daughter comes here just to fight. It doesn't help me at all!* P24 **Physical**: *Now I can no longer walk alone. I may fall due to weakness! I can't even go outside alone.* P04 **Financial**: *Ah! There are times when I think: I no longer have a home. I live in the house of others. I can't do anything.* P02 **Physical component**: *Sometimes he wants to leave the house, but as he is elderly and has a ladder to climb. Like I have here.* P74 **Social component**: *Places that care for the elderly influence for a good thing, because they show the elderly what is good for them. Do a gym. He has fun, he talks.* P12 **Employment, work and learning**: *I took the high school and technical course in nursing. I worked a little bit until I retired. Then the grandchildren were born and the daughters left them for me to take care of. I ended up quitting my job!* P82
	1. Serviço social e de saúde[6-8] 89/578	**Health promotion**: *We had a very good place here in the city, there were about 20 elderly women, we had a car, they took us for a walk, to visit places we didn't know, they had a party at Christmas.* P33 **Disease prevention**: *I always go to the clinic there, I consult there and they ask me for tests.* P51 **Healing services**: *I had a heart problem, had tests to find out and had an operation. Even the pressure was very good.* P23 **Long-term assistance**: *At the health center, you have 90 days to do the pressure control. I think it should be done every month. Then we would be more relaxed.* P12

Determinants		
	2. Comportamentais[6-8] 87/461	**Physical activity**: *The older person has to want to try to do gymnastics, a walk and any activity so as not to be just thinking that he is old.* P74 **Healthy eating**: *Each one has a different type of food, which contributes to aging differently in each one.* P12 **Abstinence from smoking and alcohol**: *The guy who uses alcohol gets older from one year to the next. The one who uses drugs, worse.* P14 **Correct use of medicines**: *The elderly should take more care of medicines and take everything right and at the right time.* P89
	3. Pessoais[6-8] 88/402	**Intergenerational responsibility**: *I have my mother who is 93 years old. Only now that she is more dependent, after she discovered Alzheimer's, then we have to help a little to take care of her.* P14
	4. Ambiente físico[6-8] 88/261	**Safe housing and neighborhood**: *Many children abandon the elderly. I find that very sad.* P23 **Risk of falls**: *The difficulties are when crossing the street, you can lose your balance!* [...] *I have a lot of difficulty crossing.* P31
	5. Sociais[6-8] 89/426	**Social support**: *Depending on the friends we have, they are practically relatives, brothers and sisters. I have one like this, I've known him for 20 years.* P10 **Protection**: *The elderly must respect a child. And the child has to respect the elderly as well.* P50 **Opportunities**: *I never got to study. I was not raised by my parents. At the age of two, my parents were no longer alive.* P17
	6. Econômicos[6-8] 21/39	**Income**: *I need to take care of my health, I have no money. What I have is practically just enough to eat. I live with only 250 reais!* P34 **Work**: *Employment is complicated! At my age, I have an additional degree of study and experience in the field, it is difficult to achieve good things.* P18 **Social protection**: *My children are very good to me. My grandchildren are always here at home. I feel happy about it!* P2

Source: Content extracted from the Nvivo Pro 11® program®.
Note: (*) - the numbers present in the circle charts depict pillars and determinants [6-8].

DISCUSSION

The predominance of women (62.4%) among the participants corroborates the feminization process of aging internationally identified, with the current life expectancy in Brazil being 79.6 years for women and 72.5 years for men[13,18].

Gender, as a transversal determinant of active aging, is capable of influencing different ways of thinking, feeling and behaving socially. Thus, the determinant gender can adapt to the different political options established in each country, aiming at optimizing its positive effects on the well-being and quality of life of the elderly[7,19].

The longevity of the female gender, in the case of Brazil (average of seven years longer than men) can be attributed to: higher male mortality rates; gradual and significant drop in annual maternal mortality rates; hormonal production of female estrogen; higher prevalence of risk behaviors associated with traffic and male work; lower rates of smoking and drinking in women and greater adherence of women to health programs and services[19].

The predominance of skin color declared brown (51.6%) is similar to the national estimate, which is 46.7%, with slight regional variations[13,18]. This characterization can also be explained by the Brazilian miscegenation itself, a process that has been going on for dozens of years and is justified by the diverse origin of the colonizing peoples, in which the first national populations were from different locations in the world (main peoples: indigenous, Africans, Europeans and Asians)[13,18].

The average of four children among participants with a variance of up to 21 children symbolized a national prevalence of large families, when compared to the standard of developed countries. A high offspring among people aged ≥65 years forms a large family nucleus capable of integrating the elderly into their socio-family context and contributing to intergenerational coexistence[13,18].

Evidence that Brazil is in the process of population aging is confirmed by observing the average number of children currently estimated by each woman, which is 1.77, which is equivalent to a drastic change in the population profile in relation to the offspring, with strong immediate impacts on population growth and, in the medium term, on economic and political contexts[13,18].

Regarding the birth rate, it was brought to the people's attention the fact that, in 2015, the Chinese one-child policy was replaced by a universal two-child policy. A recent study showed that the benefit of this change was the reduction in the number of abortions and unregistered children. It should also be noted that the effects of the new policy on the shrinking of the workforce and the rapid aging of the population will not be evident for two decades and that, during this period, more solid political actions will be needed to meet social, health and social needs. care for the elderly Chinese population[20]. It is also worth mentioning the impact resulting from birth control and family planning on the availability of an intergenerational support network for the elderly, a fact that should be the focus of public policies[13,21].

The low level of education of the participants can be justified by the difficulties in accessing education (literacy and professional training) during their youth compared to current possibilities, in addition to their low adherence to different public and private literacy programs[13,18]. In this context, mention should be made of the current Brazilian illiteracy rate, which is still high (people ≥60 years: 20.4%), almost three times higher than the estimate of the total population (age ≥15 years), which is 7, 2%[13.18].

The implication of low national education reflects, from a political and economic point of view, a population susceptible to: unemployment, low income, alienation, hunger and lower levels of access to social resources and health services. The possible approximation between low schooling and social exclusion takes on a significant character when considering the difficulties of access of this population to health services, justice, culture and favorable living and working conditions[13,18]. The low level of education of the participants also corroborates the

dichotomous predominance of professions in adulthood, which are linked to domestic services among women and civil construction among men, which justifies the low income.

It should be noted that the education received in childhood and youth, combined with permanent learning opportunities, can help people to develop their skills and the confidence necessary to adapt and remain independent as much as possible[13-19].

The predominant occupation of retirees is consistent with the age group of the participants (age ≥65 years), since, as predicted by Brazilian legislation, the beginning of current retirement is 55 years for women and 60 years for men[12,13]. From an economic perspective, 89.2% of participants received ≤ two minimum wages, which represented low income (from: retirement and/or pension resulting from the death of their spouse) due to poorly paid professional activity.

The subjects' average retirement time was 9.5 years, although the variability from 0 to 37 years of benefit expresses a diversity found in the time of retirement among the participants. These data corroborate the calculation regarding the age at which people currently retire in relation to current life expectancy (age criteria) when the maximum average benefit time would be 24.5 years for women and 12.5 years for men[13].

Culture is defined as something capable of shaping the way people age, being, therefore, the second transversal determinant and, together with gender, it is able to exert different types of influence on all determinants of active aging[7,8].

From the analysis of the participants' discourse, through the international political outlines presented, it was possible to establish three dimensions of discursive and comprehensive analysis according to each of the categories.

The engagement, socialization and intergenerational coexistence axis encompassed concepts from different aspects of international aging policies, namely: a) Active aging: participation pillar, social and behavioral determinants; b) Successful aging: social and engagement component; c) Key axes of intergenerational coexistence: solidarity and intergenerational dialogue; volunteering and civic participation and knowledge and social awareness.

Participation, in the conception of the interviewed elderly, was linked to different types of activities: social, economic, cultural and spiritual. The active aging policy defends the need to support the active, productive and beneficial contribution that the elderly can offer to society when performing (in)formal work, unpaid activities, in the family, social, religious or voluntary occupations[8,21].

The social determinants presented depend on the conditions of social support, protection against violence and abuse and opportunities for permanent education and learning (conditions of the way in which social engagement is established)[7,8].

Social support, educational opportunities and lifelong learning, peace and protection against violence and abuse are essential determinants related to the social environment, capable of stimulating the pillars of health, participation and security, as they people age[7,8]. The risks of the elderly acquiring some type of disability and a shorter life expectancy increase when exposed to loneliness, social isolation, illiteracy, limited learning opportunities, abuse and conflicts[7,8].

Abuse or mistreatment of the elderly is considered a single or repeated act, or the lack of an appropriate action, which occurs within the scope of any relationship where there is an expectation of trust, which causes some type of harm or distress. Within this scope are included: physical, sexual, psychological, financial abuse and neglect. Elderly abuse is considered a violation of human rights, capable of causing injuries, illnesses, loss of productivity, social isolation and despair[11,12].

The behavioral determinants were related to physical activity, healthy eating, abstinence from smoking and alcohol and correct use of medications that are factors capable of influencing

the prevention of functional decline, reducing the risk of disease, longevity and promoting quality of life. .

Problems related to food in all age groups include: malnutrition and excessive calorie consumption[8,13]. These problems can be related to the choices for inappropriate foods, the appearance of illnesses and the use of medications, the loss of teeth, social isolation, deficiencies (cognitive or physical) capable of inhibiting the ability to buy or prepare food. Excessive calorie consumption is considered a risk factor for the onset of obesity, chronic diseases and deficiencies during the aging process[8-13].

The behaviors associated with smoking increase the risk of people developing diseases such as lung cancer and can also contribute to the loss of functional capacity such as decreased bone density, muscle strength, and respiratory function. and it can also interfere in the effect of medications of continuous use. The damage from smoking is cumulative and long-lasting and can lead to the development of numerous diseases. The risk increases according to the duration and number of exposures of each person[8-13].

The changes in metabolism that accompany the aging process increase people's susceptibility to alcohol-related illnesses (malnutrition and diseases of the pancreas, stomach and liver). They also increase the risk of injuries and falls associated with alcohol consumption and potential risks related to the concomitant use of alcohol and medication[3,7].

The prevalence of chronic-degenerative diseases, as people age, is configured in the use of medications in excess, which can be justified by self-medication (medicines purchased without a prescription) and by the excess of medical prescriptions made for the elderly, especially women, for the constant search for health services[7,8].

The emergence of health problems induced by diagnoses/treatments and/or caused by the excessive use of medications common to elderly people, due to drug interactions, inadequate dosages and unpredictable drug reactions, is associated with the occurrence of iatrogenesis over the years[4,5].

Successful aging, linked to the participation pillar, had its social and engagement component related to the key axes of intergenerational coexistence, solidarity and intergenerational dialogue; volunteering and civic participation and knowledge and social awareness.

Engagement in activities that involve leisure, work, family relationships and religious practices in successful aging is influenced by the levels of satisfaction with the profession, social support, intergenerational and contemporary coexistence and the receipt of adequate benefits, pension and retirement[9- 10].

Participation in social, economic, cultural and spiritual activities can be optimized when the labor market, employment, education, social and health policies and programs to support people in the process of aging act in accordance with human rights fundamental, the capacities, the needs and the preferences of each elderly person so that they can remain active and productive towards society in a (un)paid way as they age[11-13].

Volunteering provides the elderly with new bonds and intergenerational coexistence and with their contemporaries, linking them to social support, which, if not adequately present to life and health conditions, can contribute to: increased morbidity and mortality, emergence of psychological problems, decline in physical/mental health, reduced feeling of general well-being and quality of life[6-8].

The participation pillar can be considered the broadest and includes the inclusion of the elderly in social, economic, cultural and spiritual activities. It depends not only on a specific determinant, but is related to all other determinants, since the active and successful engagement in activities corroborates the fulfillment initially of the demands related to the health and safety pillars[7,8].

The second axis, “Health, well-being and support networks”, encompassed the political dimensions: a) Active aging: health pillar; determinants of social and health services; b)

Successful aging: components of functional and cognitive skills, reduction of diseases and healthy lifestyle habits; c) Key axes of intergenerational coexistence: health, well-being and living conditions.

The health pillar is related to behavioral and environmental risks, functional decline, health protection factors and the appearance of comorbidities[7-8]. In the health pillar, it is possible to add the consensus of scientific evidence that the health-disease continuum is the result of the combination: genetic, biological, psychological, environmental, lifestyle, food and luck[6,13].

The determinants of social and health services involve actions to promote health, disease prevention, curative services and long-term care. Health promotion is the process capable of allowing people to obtain certain control and/or improvement in their health conditions; disease prevention includes measures to protect and control diseases typical of senility (chronic-degenerative, non-communicable diseases and/or injuries)[6,8].

As people get older, the demand for healing services, assistance in the short, medium and long term and pharmacological treatment capable of delaying, relieving or treating the signs and symptoms resulting from the emergence of comorbidities and promoting quality of life increase. This situation requires a renewed effort to guarantee access to essential and safe clinical and pharmacological treatment appropriate to the needs of these people[13,19].

The health dimension in relation to successful aging has components of functional and cognitive skills, reduction of diseases and healthy lifestyle habits. It is linked to the key axes of intergenerational coexistence: health, well-being and living conditions.

The active aging policy states that older people can enjoy quality lives, remain healthy and able to take care of their own lives as they age. This is only possible when the behavioral and environmental risk factors for chronic diseases and functional decline are kept low and the protective factors are high. Thus, it is expected that the elderly people do not need the constant use of social and health services and, if they do, that they have access to these services with care for their needs and care demands, with their rights respected[8].

As a determinant of successful aging, associated with the health pillar, the emotional dimension (satisfaction with general life and health/disease continuum) and personal dimension (attitudes favorable to aging, sense of control and motivation to transmit knowledge/experiences) can also be included. of life intergenerationally)[7,8]. (Ribeiro, 2009, Variability in active aging according to gender`, age and health}

The last axis, social security, adaptation and quality of life, as a political dimension, included: a) Active aging: safety pillar; determinants: physical, personal and economic; b) Successful aging: physical and social components; c) Key axes of intergenerational coexistence: employment, work and learning. The active aging policy presents the elderly person's right to safety in the following dimensions: social, physical and financial, and emphasizes the need to ensure it: protection, dignity and assistance. Such understanding can be captured from the speeches presented.

The determinants related to the physical environment (housing, safe neighborhood and risk of falls), social environment (social support, protection against violence and abuse, opportunities for education and lifelong learning) and economic (income, work and social protection) constitute the pillar of security and deal with the promotion of security (social, physical and financial)[8,9].

Regarding the determinant physical environment, elderly people who live in risk environments or areas with multiple physical barriers are more prone to social isolation, depression, physical unpreparedness and mobility problems, factors that restrict/limit them, causing them to pass most of the time in your home environment. Another factor to be considered is the risks present in the physical environment, which can cause incapacitating and painful injuries to the elderly, resulting, mostly, from falls, fires and automobile accidents[10,13].

Housing conditions, as well as a safe neighborhood that is adequate to the limitations and demands of the elderly, are essential to their well-being, quality of life and security. In this sense, the location of your residence, close to family, work environment, shops, churches, social and health services and means of transport, can predict positive social interaction and, when distant, can contribute to social isolation[10, 13].

It is worth mentioning that it is important that the standards of buildings and homes take into account the health and safety needs of the elderly, avoiding obstacles in the homes, which can increase the risk of falls. These need to be corrected or removed, including: poor lighting, uneven/slippery floors, lack of handrails for support, stairs and the presence of a carpet[3-5].

Among the determinants related to the physical environment, the active aging policy also establishes as factors clean water, clean air and access to safe food, which are considered important for the population, especially for people with a profile of vulnerability (ie , children, the elderly, the disabled, with chronic and immunosuppressed diseases)[3-5]. Low income can influence the conditions of access of elderly people to nutritious food, adequate housing and care necessary for the health-disease process[19].

The concept of successful aging associated with security has physical components (physical health, functional capacity and healthy living habits) and social components (engagement and opportunities throughout life) correlated to the key axes of intergenerational coexistence: employment, work and learning throughout life[8-9].

The (inter)national policies of the aging process support the need to promote active aging. For this, health systems need to be adapted to the needs of people from the perspective of the life course, aiming at health promotion, disease prevention and equitable and equal access to quality primary and long-term care[6-10].

Social and health services need to be integrated, coordinated and cost-effective and accessible to people in the aging process and there can be no prejudice or age discrimination in the provision of care services. Their providers must treat all people with dignity and respect, regardless of age[13].

The definition of the determinants and pillars of active aging, as a (inter)national policy, was based on the principles established by the United Nations (UN) in favor of the elderly. They are: independence, participation, assistance, self-performance and dignity[20,21].

With regard to the principle of independence, it is worth highlighting job opportunities and access to other forms of income generation and inclusion in professional and/or educational programs. Participation refers to the right to remain integrated with society, to actively participate in the formulation and implementation of policies related to their well-being, in addition to the intergenerational transmission of knowledge, skills and life experiences[22,23].

Self-performance and/or self-realization refers to taking advantage of opportunities to develop their skills and potential and accessing social resources (educational, cultural and leisure). Dignity refers to the treatment of the elderly with justice free from any prejudice or discrimination (age, gender, sexuality, ethnicity, limitations, disabilities, religiosity, living or economic conditions[23,24].

The assistance principle ensures the right of the elderly, which, in Brazil, includes the principles of the Unified Health System (*Sistema Único de Saúde - SUS*): in common with the doctrinal principles (universalization, equity and integrality) and, in the form of operationalization, the organizational ones (regionalization and hierarchization, decentralization, single command and popular participation)[14,24].

The results presented include two thematic axes of the Ministry of Health's Research Priorities Agenda (MHRPA), namely: 9th - public programs and policies and 12th - health of the elderly, which comprise the 14 priority themes of scientific investigations and political initiatives in health[25].

In this context, a research, which used the deductive method, with a qualitative and descriptive approach, investigated whether the municipalities of a southern region of the state of Santa Catarina, Brazil, knew and applied the NHPE during the actions carried out in Primary Care (PC), especially in the Family Health Strategy (FHS), in the light of the constitution and the Statute for the Elderly[15]. As a result, the difficulties presented by the participants regarding two important points of the NHPE guidelines and strategies were highlighted: the lack of a planned and continuous health education policy for the elderly; and the lack of incentive to exercise social control, in the scope of either health, or the municipal health council aimed at the elderly[15].

The need to value public initiatives and decisions in the political, social and health sectors aimed at aging people and based on the interpretation of how the pillars and determinants of active aging, the components of successful aging and the key axes of intergenerational coexistence can positively influence the way people from different groups and social contexts age[26]. PNSPI, as well as the elderly's status, meets the subjects' biopolitical nature, by placing the demands for comprehensive health care as a population problem, while directing their care to the frail elderly according to their perceptions as a politicized being[27].

CONCLUSION

From the analysis of the perceptions of the elderly about human aging, it was possible to understand that this group has reified knowledge regarding all pillars, determinants, dimensions and political axes, even without actually expressing knowledge in relation to cool font.

Although the extrapolation of the results is a limitation of this investigation, it is possible to infer about the conceptions regarding the (inter)national policies of the aging process based on content analysis and fragments of illustrative discourses, which explain different dimensions of knowledge that are in line with the theoretical and political frameworks adopted regarding human aging. Thus, it is suggested to carry out further investigations on the theme in other social groups, as well as the use of different methodological designs.

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