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SPECIAL ISSUE

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Self-care practices of elderly people in rural contexts from the perspective of health vulnerability[a]

Práticas de autocuidado de pessoas idosas em contexto rural sob a ótica da vulnerabilidade em saúde

Prácticas de autocuidado de las personas mayores en contextos rurales desde la perspectiva de la vulnerabilidad em salud

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Abstract

Objective: To understand, from the perspective of health vulnerability, how older adults practiced self-care during the pandemic. **Method:** A qualitative, descriptive, and exploratory study was conducted based on the conceptual framework of health vulnerability. Twenty-two non-institutionalized older adults receiving primary health care participated in the study. Data collection occurred between July and August 2023 using semi-structured interviews. The analysis was conducted deductively, adhering to the principles of thematic analysis. **Results:** Most participants were women, with a mean age of 74.2 years. They exhibited low income and education levels, often had comorbidities, and were experiencing polypharmacy. The self-care practices identified included medication use, spiritual practices, vaccination, mask-wearing, hand sanitizer use, maintenance of treatment for chronic conditions, strengthening of family ties, and communication. **Final considerations and implications for practice:** Self-care practices reflected the interdependence of the dimensions of health vulnerability. These practices consist of elements employed by individuals when faced with illness, regardless of their health situation. The importance of understanding self-care practices and popular knowledge is evident for strengthening bonds, providing comprehensive and longitudinal care, and promoting the health of the elderly population in primary health care.

Keywords: Primary Health Care; Self-Care; Elderly; Health; Health Vulnerability.

Resumo

Objetivo: Compreender, sob a ótica da vulnerabilidade em saúde, como as pessoas idosas realizaram as práticas de autocuidado no período pandêmico. **Método:** Estudo qualitativo, descritivo e exploratório, fundamentado no referencial conceitual da vulnerabilidade em saúde. Participaram 22 pessoas idosas não institucionalizadas, atendidas na Atenção Primária à Saúde. A coleta de dados ocorreu entre julho e agosto de 2023, com entrevistas semiestruturadas. A análise foi conduzida de maneira dedutiva, seguindo os preceitos da análise temática. **Resultados:** A maioria dos participantes eram mulheres, com idade média de 74,2 anos, baixa renda e baixa escolaridade, com comorbidades e em uso de polifarmácia. As práticas de autocuidado apontadas envolveram uso de medicamentos, exercício da espiritualidade, vacinação, uso de máscaras e álcool em gel, manutenção de tratamentos para doenças crônicas, fortalecimento de vínculos familiares e comunicação. **Considerações finais e implicações para a prática:** As práticas de autocuidado refletiram a interdependência das dimensões da vulnerabilidade em saúde. Tais práticas consistem em elementos que as pessoas utilizam diante de uma condição de adoecimento, independentemente da situação sanitária vivenciada. Evidencia-se a importância da compreensão sobre práticas de autocuidado e saberes populares para o fortalecimento de vínculos, o cuidado integral e o longitudinal e a promoção da saúde da população idosa na Atenção Primária à Saúde.

Palavras-chave: Atenção Primária à Saúde; Autocuidado; Idoso; Saúde; Vulnerabilidade em Saúde.

Resumen

Objetivo: comprender cómo las personas mayores realizaron prácticas de autocuidado durante el período de pandemia desde la perspectiva de la vulnerabilidad en salud. **Método:** estudio cualitativo, descriptivo y exploratorio, basado en el marco conceptual de la vulnerabilidad en salud. Participaron 22 ancianos no institucionalizados atendidos en la Atención Primaria de Salud. La recolección de datos se realizó entre julio y agosto de 2023, con entrevistas semiestructuradas. El análisis se realizó de manera deductiva, siguiendo los preceptos del análisis temático. **Resultados:** la mayoría de los participantes eran mujeres, con edad media de 74,2 años, bajos ingresos y escolaridad, presentaban comorbilidades y utilizaban la polifarmacia. Las prácticas de autocuidado involucraron el uso de medicamentos, el ejercicio de espiritualidad, la vacunación, el uso de mascarillas y desinfectante de manos, el mantenimiento de tratamientos para enfermedades crónicas, el fortalecimiento de los lazos familiares y la comunicación. **Consideraciones finales e implicaciones para la práctica:** las prácticas de autocuidado reflejaron la interdependencia entre las dimensiones de vulnerabilidad en salud. Dichas prácticas son elementos que las personas utilizan ante una condición de enfermedad, independientemente de la situación de salud vivida. Se evidencia la importancia de comprender las prácticas de autocuidado y el conocimiento popular para el fortalecimiento de los vínculos, el cuidado integral y longitudinal y la promoción de la salud de la población adulta mayor en Atención Primaria de Salud.

Palabras-clave: Atención Primaria de Salud; Autocuidado; Anciano; Salud; Vulnerabilidad en Salud.

INTRODUCTION

Human aging, experienced worldwide and driven by increased life expectancy, is strongly influenced by the interaction between genetic factors, personal characteristics, and the physical and social environments in which people live. These interactions throughout life directly impact active, autonomous, and independent aging. Nevertheless, it is common that with advancing age, multiple chronic conditions and health vulnerabilities arise, requiring public health responses that minimize functional losses and encourage recovery and adaptation in older adults.[1]

In this context, understanding the health vulnerabilities of the elderly population is fundamental to developing effective strategies for promoting active and healthy aging. Health vulnerability is a dynamic and complex phenomenon, structured in three interdependent dimensions: individual, social, and programmatic. The individual dimension refers to personal characteristics that influence exposure to risks, such as behaviors, knowledge, lifestyle habits, and health conditions. The social dimension encompasses the sociocultural, economic, and political contexts in which individuals are embedded, including inequalities that limit access to resources and opportunities. The programmatic dimension concerns the capacity of public policies and health services to recognize and respond effectively, promptly, and equitably to the needs of different populations.[2]

The situation of the elderly population living in rural areas stands out, as they face multiple forms of vulnerability related to poor housing conditions, low levels of education, social isolation, economic difficulties, and geographical distance from urban centers and specialized health services.[3] Although there are public policies aimed at protecting the rights and promoting the health of older adults[4,5] and rural populations,[6] the aging process in these territories still reflects profound inequalities.[7]

In Brazil, according to data from the Brazilian Institute of Geography and Statistics, the elderly population (defined as those aged 60 years or older) reached 32,113,490 individuals in 2022, corresponding to 15.6% of the country's total population.[8] This number represents an increase of 56.0% compared to 2010, evidencing an accelerated process of population aging.[8] This age group generally has lower levels of education, worse socioeconomic conditions, and greater difficulty accessing specialized health services.[9] When interrelated, these factors exacerbate inequalities and deepen situations of health vulnerability, especially in the context of territorial disparities and limited healthcare resources.

Given this scenario, self-care practices emerge as fundamental strategies for promoting health, coping with adversity, and strengthening resilience in situations of health vulnerability. Self-care comprises a set of voluntary and intentional practices carried out by the individual to preserve their life, health, and well-being.[10,11] Such practices are influenced by several factors, such as age, gender, autonomy, health conditions, sociocultural aspects, family structure, physical environment, and access to health system services and resources.[10,11]

Thus, it is essential to deepen our understanding of the self-care practices adopted by older adults, especially those living in rural areas and facing multiple health vulnerabilities. Understanding self-care practices contributes to the achievement of the Sustainable Development Goals,[12] especially those related to health promotion, well-being, and the reduction of inequalities.

Nevertheless, despite the significant scientific production on the impacts of the COVID-19 pandemic on the elderly population,[13,14] there are still few studies that analyze self-care from the perspective of health vulnerability, especially in rural areas and in the context of Primary Health Care (PHC). Furthermore, there is a gap in knowledge about the role of nursing in managing the repercussions of the COVID-19 pandemic, especially regarding the monitoring of the well-being of older adults and continuity of care.[15]

From this perspective, it is understood that older adults adopted various self-care practices during the pandemic period, many of which reflect experiences that transcend the context of a health emergency. Given the above, we aimed to understand, from the perspective of health vulnerability, how older adults performed self-care practices during the pandemic period.

METHOD

This study is part of a larger research project entitled "Vulnerabilities and repercussions of the Covid-19 pandemic on elderly people: mixed method study."[16] It is a qualitative, descriptive, and exploratory investigation, adhering to the Consolidated Criteria for Reporting Qualitative Research (COREQ),[17] and based on the conceptual framework of health vulnerability.[2] This approach enabled a comprehensive interpretation of the results, considering not only clinical aspects but also the complex interactions among individual, social, and programmatic factors that influence the health, well-being, and self-care practices of the elderly population.

The quantitative stage of the research aimed to identify elderly individuals in situations of vulnerability. To this end, a sociodemographic questionnaire on health conditions and instruments for screening situations of vulnerability were applied to a sample of 356 non-institutionalized elderly individuals cared for by PHC in a rural municipality located in northwestern Rio Grande do Sul State (Brazil). The instruments used included the Clinical-Functional Vulnerability Index (IVCF-20),[18,19] the Geriatric Depression Scale (EDG-15),[20-22] and the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST),[23,24] employed to identify the risk of violence against older adults.

The qualitative phase, which is the focus of this study, was conducted following the analysis of the quantitative data. For convenience, 22 older adults who exhibited at least one identified situation of vulnerability from the applied instruments were selected. The inclusion criteria were being ≥ 60 years of age, receiving services from the municipality's PHC, not being institutionalized, and presenting some situation of vulnerability. The exclusion criterion was the presence of conditions that made participation in the interview impossible, such as cognitive deficits or physical and emotional discomfort.

Data collection occurred between July and August 2023 through semi-structured interviews conducted exclusively by a female researcher, a nurse, who was previously trained and experienced in qualitative research. The interviews were conducted at participants' homes and recorded using a cell phone recorder. Voluntary participation was formalized by signing the free and informed consent form. The interviews averaged 22 minutes in duration and were concluded based on the criterion of data saturation,[25] identified from the recurrence of information. Subsequently, the audio recordings were fully transcribed using Microsoft Word software, version 2013. There was no data validation because conducting interviews at participants' homes limited the ability to reaccess them.

Data analysis was conducted deductively, based on the health vulnerability framework,[2] which allowed for the interpretation of findings organized into three interdependent dimensions: individual, social, and programmatic. Subsequently, thematic analysis was performed following Minayo's[26] operational proposal, developed in four stages: (1) exploratory phase involving transcription, comprehensive reading, and organization of empirical material; (2) interpretive phase, wherein successive readings were performed to identify internal connections, meanings, and interpretations based on data ordering and classification; (3) final analysis, wherein the data were understood and interpreted in light of the scientific literature; and (4) report preparation, featuring the systematization and presentation of the results obtained. It should be noted that no software was used for data analysis.

The statements were coded with the letter "N" for nurses interviewed, followed by a sequential number, from N1 to N22, to preserve the anonymity of the participants. All ethical principles for research involving human subjects were observed. The overarching research was approved by the Institutional Research Ethics Committee of Universidade Federal do Rio Grande do Sul, under opinion no. 5,639,338 and CAAE no. 61689722.3.0000.5346.

RESULTS

Regarding the sociodemographic profile of the participants, their ages ranged from 60 to 88 years, with a mean age of 74.2 years. Most (16, 72.7%) were female. Concerning education, 21 (95.4%) participants had no formal education or had only completed elementary school. In terms of marital status, 12 (54.5%) individuals were married, eight (36.4%) were widowed or divorced, and two (9.1%) were single. Regarding spirituality and religious beliefs, 14 (63.6%) identified as Catholic, while eight (36.4%) followed evangelical denominations.

The monthly income of 16 (72.7%) participants was up to one minimum wage, equivalent to BRL 1320.00, whereas six (27.3%) reported a higher monthly income. All elderly participants reported being diagnosed with at least one chronic disease, notably hypertension, diabetes mellitus, depression, and cancer. Additionally, all reported daily medication use, with 12 (54.6%) using four or more drugs simultaneously, indicating a situation of polypharmacy.

Through deductive and thematic analyses, we constructed the category "Self-care practices adopted by elderly people from the perspective of health vulnerability." The results were organized into subcategories corresponding to the three dimensions of health vulnerability: individual, social, and programmatic.

The self-care practices identified are summarized in Figure 1, which presents the interdependence among these dimensions in an integrated manner. The illustration shows how individual factors (such as health habits, spirituality, and adherence to treatments), social factors (family support and community ties), and programmatic factors (access to health services and policies) are closely interrelated and mutually influential, directly affecting the strategies adopted by older adults. The figure provides a visual guide to understanding the subcategories discussed below, allowing for a concise visualization of the complexity and interconnection of the findings.

Health vulnerability: individual dimension

At the individual level, the self-care practice adopted by older adults in coping with adversity primarily focused on measures aimed at preserving physical and mental health. Maintaining the continuity of treatment for chronic diseases during the pandemic was widely mentioned by participants as a priority. Furthermore, for those using polypharmacy, the support of family members was sometimes indispensable in the organization and proper management of medications.

> *I take nine pills a day, just for one condition. This one is for rheumatism, and then there are others for blood pressure, calcium, and vitamins.* (N21)

> *At this age, I can walk well, though sometimes I stumble a little. [...] After my husband passed away, it worsened. Sometimes I'm fine; other times, I feel very dizzy. I take medicine for labyrinthitis, for blood pressure, and when necessary, a pill for pain.* (N11)

In addition, older adults reported significant impacts on their physical and emotional health resulting from both social isolation and the sequelae of COVID-19. In response to these conditions, they sought support from health professionals, began medication treatments, and adopted strategies to adapt to the changes imposed by the pandemic on their routines and quality of life.

> *Because of the pandemic* [I felt discouraged]. *I was doing fine on my own. Then, when I started having those 'things,' that's when it started [...] I couldn't walk from here to there and back because I would return staggering; I had to hold on to something. Then she* [my wife] *saw it and said that I must be sick.* (N10)

Despite the emotional suffering caused by social isolation and the loss of family and friends, older adults reported finding a source of protection, comfort, and strength in spirituality and religious faith to face the adversities and illnesses that arose during the pandemic period.

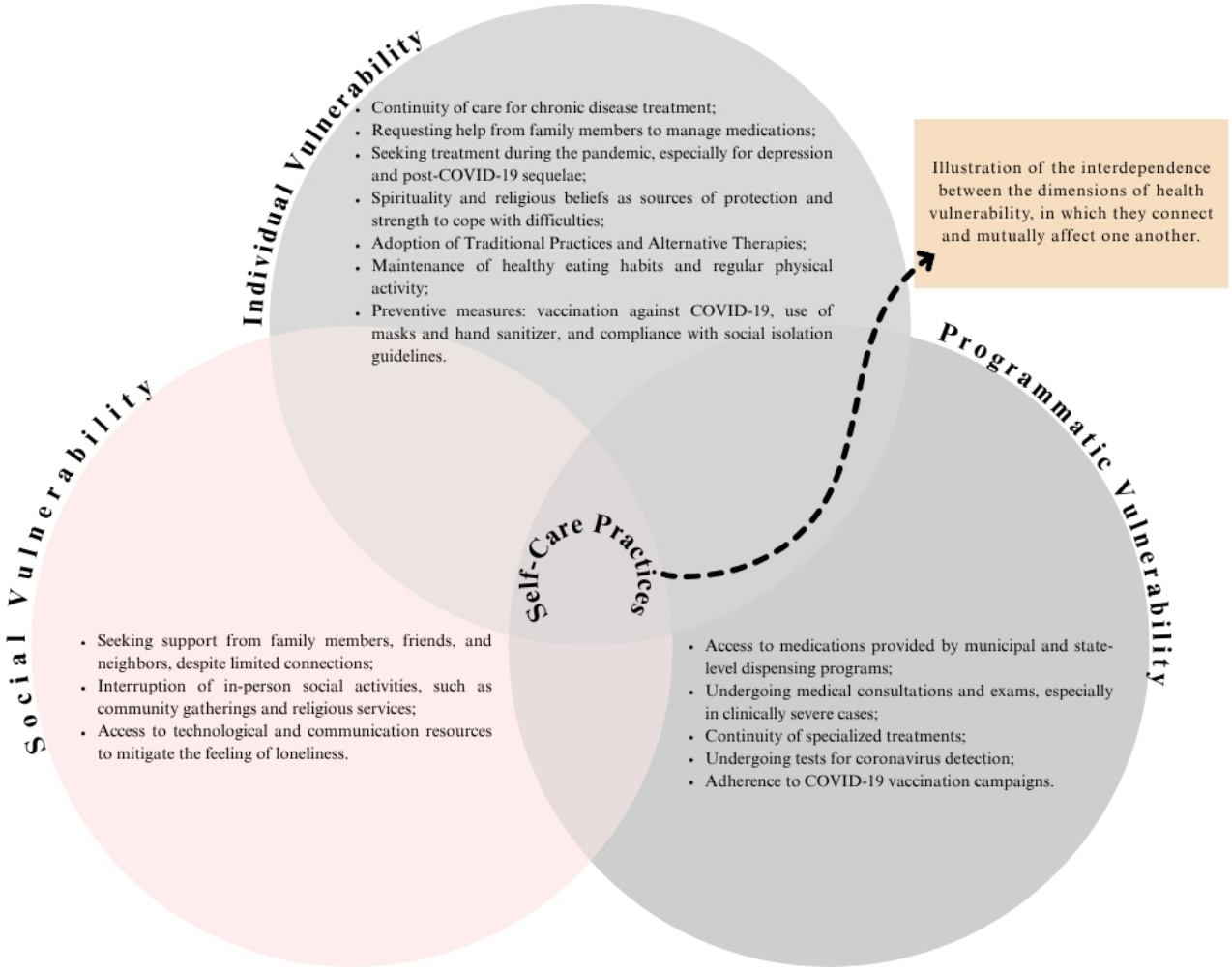

Figure 1. Self-care practices adopted by older adults from the perspective of individual, social, and programmatic dimensions of health vulnerability in a rural municipality in Rio Grande do Sul, Brazil. 2025.
Source: Prepared by the authors, 2025.

> *We live by faith. It is God who knows how long we can stay on Earth. The day He calls us—what He allows—no one can take away.* (N14)
>
> *We have to have our faith, keep our faith.* (N6)

The adoption of traditional practices and alternative therapies was also mentioned as an important self-care strategy among older adults. These practices, usually carried out through infusions and teas, aimed to promote well-being and complement conventional drug treatment.

> *I drink a lot of homemade tea. Guavirova leaf tea, artichoke tea, mango tea. I drink all of that, so I don't have anything like that. The only thing I take is medicine for my blood pressure.* (N6)
>
> *I drink a lot of tea and make my own flu syrup. In my garden behind* [the house], *I have all kinds of tea.* (N7)

The emphasis on maintaining healthy eating habits as a critical self-care practice was underscored, highlighting specific measures such as reducing sodium intake to manage high blood pressure and adapting diets to accommodate chewing difficulties. Additionally, regular physical activity was identified as a strategy for countering sedentary lifestyles and preserving physical independence during the pandemic.

> *More bean soup, rice, and cassava; I can't eat meat.* (N1)
>
> *I get up early, take my medicine, drink a little chimarrão, and then I have something to eat. I eat a banana and drink coffee. I walk around. I light the fireplace when it's cold. But I don't sit still; I can't sit for hours like that, I have to keep moving.* (N11)

During the pandemic, older adults began to incorporate new precautions into their daily routines. Among the major changes were preventive practices such as adherence to vaccination,

regular use of masks and hand sanitizer, and compliance with social distancing guidelines, actions that significantly characterized the COVID-19 pandemic period.

> *I got three vaccines, took good care of myself, didn't receive visitors, kept my gate closed. And I went out wearing a mask and using hand sanitizer all the time; I would apply it when I left and again upon arriving at places.* (N12)

> *I went there because of my treatment. I went there, came home. And we stayed indoors. Not even the girls* [daughters] *came here. I didn't drink chimarrão with anyone, it was just the two of us here and that was it, I didn't talk to anyone, I didn't go out on the street. I only went out for treatment*. (N6)

The findings revealed that, in the context of the COVID-19 pandemic, older adults implemented various self-care practices at the individual level, focusing on preserving physical and mental health. Continuing treatments for chronic diseases, appropriate medication use with family support, seeking professional care when new symptoms arise, and adopting preventive habits were widely reported strategies.

Moreover, emotional support through faith and spirituality, the use of alternative therapies, and valuing healthy eating and physical activity as means to maintain autonomy and well-being stood out. These practices indicate that self-care among older adults extends beyond biomedical guidelines, intertwining with popular knowledge, beliefs, and emotional bonds, thus reinforcing the complexity and comprehensiveness of health care at this stage of life.

Health vulnerability: social dimension

This dimension encompasses interpersonal support and interactions within the familial and community context. Older adults reported seeking support from family and friends, particularly children and neighbors, when they needed assistance with daily activities and challenges during the COVID-19 pandemic.

> *I get along with all my neighbors here, they all love me, thank God. I always say that friendship is our defense—friendship and health.* (N11)

> *With my daughter, my* [son], *and my neighbors. My* [husband's] *cousin also helps me. If I need medicine, I give him the prescription and he goes to the pharmacy to buy it.* (N1)

The social interaction of older adults was affected by the restrictions imposed during the COVID-19 pandemic. Many ceased in-person activities, such as community gatherings and religious celebrations, but endeavored to maintain, although in a limited capacity, contact with family and neighbors, preserving emotional bonds essential to their well-being.

> *We felt it. What could we do? Fear, but always taking care of ourselves—masks and everything. So we didn't go to the ranch, we didn't do anything, we stopped there too [...] out of fear.* (N18)

> *Masks, yes. But take care of what? Here at home, I kept the same routine as always, the neighbor came here and we drank mate. We didn't forbid drinking or making mate, and it worked.* (N21)

Although visits were restricted, meaningful contact with friends and family was identified as an important form of emotional support. In this context, access to means of communication, especially the use of cell phones to maintain ties with loved ones, was highlighted. Additionally, radio and television helped alleviate feelings of loneliness, underscoring resilience as a fundamental element in coping with the pandemic scenario.

> *I get up and turn on the radio. I remember to turn it on, but I forget to turn it off. It stays on all day. If you want to see me get bored, just leave me without news, without a radio, in a silent, quiet place.* (N9)

Despite the limitations imposed by social isolation, bonds with family, neighbors, and friends were preserved and imbued with new significance, remaining essential sources of emotional support. The strategies employed demonstrated adaptability and resilience in response to the disruption of face-to-face activities and reduced social contact. These elements underscore the importance of support networks for promoting well-being and maintaining the physical and emotional health of older adults in crisis contexts.

Health vulnerability: programmatic dimension

Regarding self-care practices associated with the programmatic dimension of health vulnerability, participants emphasized the continuity of specialized treatments for chronic conditions. However, this continuity was frequently hindered by strict pandemic containment measures, such as the suspension of outpatient care and restrictions on companions in referral units. These conditions led to feelings of insecurity, abandonment of clinical follow-ups, and, occasionally, diagnostic delays.

> *I fell while walking to the doctor's office. I went to the clinic to get a referral to see a specialist, and on my way home, I tripped, twisted my foot, and fell* (N10).

> *Inside that CACON, the secretaries would leave the room and say: only patients are allowed inside, companions must leave because the pandemic is killing people. Leave, don't stay, only come back when the doctor calls you to the office. It was terrifying!* (N6).

The elderly also reported that when they exhibited flu-like symptoms, they sought medical attention and underwent tests to detect the coronavirus, demonstrating an active approach to

managing their health. Additionally, there was significant adherence to COVID-19 vaccination campaigns, with most elderly individuals receiving at least three doses of the vaccine.

> *I went there and had several tests done. Something started in me when COVID began. You have to do it. I had the blood test done there at the lab. Then I went to the hospital and had the swab test done* (N13).
>
> *Yes, all* [the vaccine doses]. *And the booster now that it's available, and the flu shot too. Everything, if we take good care of ourselves* (N4)

It became evident that, in the context of the programmatic dimension of health vulnerability, self-care practices during the pandemic were defined by efforts to maintain treatment for chronic conditions, even amid the limitations imposed by containment measures. An active stance was also observed among older adults in response to the threat of the coronavirus, demonstrated by the pursuit of testing when displaying flu-like symptoms and a notable adherence to vaccination campaigns, reflecting a dedication to self-care.

DISCUSSION

From the standpoint of health vulnerability, understanding how older adults practiced self-care during the pandemic revealed that these practices involved the consistent use of medications, family support, the adoption of preventive measures against COVID-19, the exercise of spirituality and religious beliefs, alternative therapies, and healthy habits. Older adults endeavored to maintain social connections through communication and faced obstacles in accessing health services, although they widely adhered to vaccination. These practices highlighted the interdependence between individual, social, and programmatic aspects, underscoring the resilience of older adults and the necessity for more effective public policies that address their needs.

The sociodemographic profile and health conditions observed align with findings from a study[27] conducted with 496 elderly individuals, wherein a predominance of women was identified, with an average age of 69 ± 76.8 years. Hypertension was the prevalent comorbidity, and most participants exhibited risk or clinical-functional vulnerability. Additionally, the analysis revealed that 13.91% of the individuals used polypharmacy, a practice noted in 46.5% of individuals with vulnerability.

Regarding self-care practices at the individual level, the continuous use of medications for chronic diseases, support from family for medication management, initiation of treatments for depression and COVID-19 sequelae, and valuing spirituality and religiosity were prominent. Traditional health practices, the use of alternative therapies, and preventive measures such as vaccination, mask-wearing, hand sanitizing, and social distancing were also reported. In agreement, another study[28] highlighted the reinforcement of preventive practices as a self-care strategy. Spirituality and religiosity proved to be significant resources for maintaining health as they offer opportunities for connection and reframing experiences, transcending material aspects. Such practices facilitate the subjective processing of painful experiences, such as those imposed by a pandemic.[29]

In the social dimension of vulnerability, practices related to support from family and friends, discontinuation of in-person social activities, and the use of communication tools, such as cell phones, radio, and television, were prevalent. These strategies aimed to preserve social distancing while mitigating feelings of loneliness. These findings are consistent with other studies that indicate the strengthening of emotional bonds[30] and the use of technological[27] resources as forms of self-care adopted by older adults in the pandemic context.

With regard to vulnerability, self-care practices were conditioned by the organization of health services, particularly to sustain specialized treatments. Throughout the pandemic, there was a recognized need to expand PHC to meet the needs of vulnerable populations and at-risk groups, such as the elderly and individuals with comorbidities, who experience situations of isolation or restrictions that were exacerbated in the context of adversity.[31] Vaccination was also acknowledged as a protective factor and a self-care practice adopted by older adults during the COVID-19 pandemic. It is worth noting that vaccination is established as the most effective strategy for preventing vaccine-preventable diseases, responsible for significant health indicator advancements. Even if the vaccine does not prevent infection, it can reduce the virus's reproduction, leading to milder illness and decreased transmission.[31]

Hence, considering that older adults engage in self-care practices, health professionals must recognize and incorporate these practices throughout the entire care process. Attending to this age group requires a sensitive and comprehensive approach, particularly in pandemic situations that necessitate interventions focused on infection prevention and control, as well as on maintaining chronic treatments and timely diagnoses. This care must be even more attentive to older individuals with fragile social support, given their increased risk of developing fear, sadness, anxiety, and depression.[32]

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

This study demonstrated that self-care among older adults is influenced by a complex interaction of individual, social, and programmatic dimensions of health vulnerability, directly impacting their ability to care for themselves. It also revealed that these practices are closely associated with the social determinants of health. Despite facing challenging contexts, such as social isolation and limited access to health services during the pandemic, older adults employed cultural knowledge, spirituality, health guidelines, and emotional strategies as essential resources for self-care.

The understanding of self-care among older adults surpasses the biomedical perspective, incorporating popular knowledge,

traditional practices, and spiritual beliefs as legitimate and effective elements of care. This acknowledgment is crucial for developing more sensitive and effective PHC interventions, as it facilitates the creation of strategies tailored to the cultural and social contexts of the population.

Furthermore, the findings emphasize the need for public policies that consider the multiple dimensions of vulnerability, expand access to health services, and strengthen social support networks to ensure equity in aging. Such policies should promote the integration of popular knowledge and biomedical practices, encouraging healthy aging, autonomy, and social inclusion.

Although the study adhered to methodological rigor consistent with qualitative research, some limitations must be acknowledged: the possibility that some older adults could not fully express their self-care practices due to their vulnerability or insecurity in discussing the topic, as vulnerability is inherently sensitive; the selection of participants based on convenience, limited to older adults in a single rural municipality identified as vulnerable, may have restricted the diversity of perspectives and reduced the transferability of the findings; the interviews were conducted by a single researcher without subsequent feedback to participants to validate responses or interpretations, which could have introduced biases.

Lastly, this study aspires to contribute to promoting the autonomy and independence of older adults in self-care practices, expanding the scientific literature on the subject. It also aims to raise awareness among health professionals, particularly nurses, of the importance of attentive listening, longitudinal follow-up, and strengthening community ties. These practices should recognize and integrate various forms of self-care into clinical practice, as well as the multiple dimensions of vulnerability, thereby promoting autonomy, quality of life, and active citizenship in aging. Additionally, it is imperative to highlight the urgent need for public policies and integrated care practices that ensure equity throughout the aging process.

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DATA AVAILABILITY RESEARCH

The contents underlying the research text are included in the article.

CONFLICT OF INTEREST

No conflict of interest.

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