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Self-care behaviors in older adults: a qualitative study in a Mexican population

Prácticas de autocuidado en adultos mayores: un estudio cualitativo en una población mexicana

Práticas de autocuidado em idosos: um estudo qualitativo numa população mexicana

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Abstract

Background: Older adults perform self-care activities based on common knowledge, which should be valued by the nursing team.
Objectives: To describe and analyze the self-care behaviors of older adults in a Mexican population.
Methodology: Qualitative ethnographic study, using Leininger's qualitative research method.
Results: Seventeen older adults were interviewed. The analysis resulted in 4 explanatory patterns: 1) I keep my peace of mind through what I think, feel, and believe; 2) I watch my diet and pay attention not only to what I eat but also how I eat it; 3) Staying busy is what keeps me going; 4) and Seeking help and helping myself. The following risk behaviors were identified: Postponing medical care; Self-medication; and Food-related beliefs.
Conclusion: Identifying older adults' reported behaviors would contribute to the planning of culturally-sensitive nursing interventions.

Keywords: health knowledge, attitudes, practice; aged; nursing care; culture

Resumen

Marco contextual: Los adultos mayores realizan prácticas de autocuidado con base en sus saberes populares, estas deben ser valoradas por el personal de enfermería.
Objetivos: Describir y analizar las prácticas de autocuidado que llevan a cabo adultos mayores de una población mexicana.
Metodología: Investigación cualitativa etnográfica, en la que se utilizó el método de análisis cualitativo de Leininger.
Resultados: Se entrevistó a 17 adultos mayores. El análisis originó 4 patrones explicativos: 1) Conservo mi tranquilidad a través de lo que pienso, siento y creo; 2) Cuido mi alimentación porque no solo es lo que se come, sino cómo se come; 3) Mantenerme ocupado es lo que me tiene en pie; 4) Pidiendo ayuda y ayudándose uno mismo. Las prácticas de riesgo son posponer la atención médica, automedicarse y las creencias en la alimentación.
Conclusión: La identificación de las prácticas expresadas por los adultos mayores aportaría una plusvalía en la planificación de las intervenciones de enfermería en el ámbito de los cuidados culturalmente sensibles.

Palabras clave: conocimientos, actitudes y práctica en salud; anciano; atención de enfermería; cultura

Resumo

Enquadramento: Os idosos realizam práticas de autocuidado com base no seu conhecimento popular, as quais precisam de ser avaliadas pela equipa de enfermagem.
Objetivos: Descrever e analisar as práticas de autocuidado realizadas por idosos de uma população mexicana.
Metodologia: Pesquisa etnográfica qualitativa, utilizando o método de análise qualitativa de Leininger.
Resultados: Foram entrevistados 17 idosos. A análise originou 4 padrões explicativos: 1) Mantenho a minha paz mental através do que penso, sinto e acredito; 2) Eu cuido da minha dieta porque não é apenas o que é comido, mas como é comido; 3) Manter-me ocupado é o que me mantém em pé; 4) Pedindo ajuda e ajudando a si mesmo. As práticas de risco são adiar a atenção médica, a automedicação e as crenças de alimentação.
Conclusão: A identificação das práticas expressas pelos idosos poderá constituir-se como uma mais-valia para o planeamento das intervenções de enfermagem no campo de cuidados culturalmente sensíveis.

Palavras-chave: conhecimentos, atitudes e prática em saúde; idoso; cuidados de enfermagem; cultura

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Introduction

Population aging has increased the demand for health care in Mexico, and the current health care services are unable to meet these needs (González et al., 2011). However, despite this difficulty, older adults engage in behaviors to cope with their discomfort, pain, illness, and/or disability. These invisible strategies are part of the so-called self-care system (Menéndez, 2005), through which people manage with their health problems without the intervention of health care institutions. This informal system allows reducing the demand for health services and is composed of different care domains, from alternative medicine, traditional medicine, self-medication, family and social guidance and counselling to the use of magical and/or religious entities.

Leininger and McFarland (2006) describe these strategies as cultural care actions or practices, which incorporate individuals' culture and a wealth of common knowledge. Furthermore, the authors argue that patients' adherence to treatment, the health professional/ patient relationship, and the quality of care are compromised when health professionals do not take these practices into account. Therefore, the authors suggest that health professionals should invest in knowing these practices and assessing their use, with the purpose of not only identifying and readjusting harmful practices but also promoting beneficial practices and their integration into care plans. This intervention will allow health professionals to deliver culturally appropriate care (Leininger & McFarland, 2006).

Some of these practices may derive from information that is culturally inherited - *emic* knowledge - and be complemented by information provided by health professionals - *etic* knowledge (Purnell, 1999). This combination of practices shows how professional knowledge shapes and adjusts cultural knowledge about health, thus creating new cultural health patterns.

Some of these practices focus on coping with age-related conditions, chronic diseases, and mental disorders (Melguizo, 2012). The several studies on this topic (Hernández Zambrano, Hueso Montoro, Montoya Juárez, Gómez Urquiza, & Bonill de las Nieves, 2016) describe these practices and suggest that they should be further analyzed. However, there is no specific study on how self-care-practices actually benefit older adults. Some authors have studied isolated practices, such as eating habits, physical activity, and lifestyles (Mikel, Cadore, & Casas, 2014; Orb, 2004; Vadillo, González, López, Zarrabeitia, & Pérez, 2012). It is important to identify self-care practices and determine if they can be integrated into care plans.

The objective of this study was to describe and analyze the self-care behaviors of a group of older adults in a community in the State of Mexico. This information will be useful to the development of health promotion programs aimed at this population.

Background

The State of Mexico has recently created geriatric clinics, with the purpose of designing an elderly care model in a region where the population has increased over the past decade, as a result of the decentralization of the Mexico City. This region, located in the Northwest, has become a highly populated area, with an increasing older population, which has caused not only demographic, but also social, economic, and cultural changes. Health care systems have also been affected to the extent that they are not able to adequately meet the health needs of this population. The creation and implementation of a home care model cannot and should not ignore older adults' self-care behaviors based on common knowledge and personal experience. The analysis of these behaviors will allow health professionals to identify the most beneficial practices for older adults and integrate them in a home care model.

Research questions

Which self-care behaviors are performed

by older adults in their daily lives?
What are the benefits of self-care behaviors reported by older adults based on their experience?
Which self-care behaviors pose a risk to older adults' health?

Methodology

In this qualitative and ethnographic study, 17 older adults from a community in the State of Mexico were interviewed. Participants were selected using the purposive sampling technique until data saturation was achieved. They were selected during occupational workshops at a geriatric clinic. The researcher personally contacted the older adults and invited those who showed greater autonomy. The following inclusion criteria were applied: individuals aged over 60 years who agreed to participate in the study and who were functional and capable of expressing themselves. Data were collected using semi-structured interviews. The initial plan was to conduct the interviews at home in order to contextualize behaviors; however, for safety reasons, most participants preferred to be interviewed at the geriatric clinic, where the comfort and privacy conditions were ensured. On average, each interview lasted 40 minutes and was recorded after the participants' consent. The triggering questions focused on older adults' narrated experiences, moments, and actions aimed at improving their health status or preventing diseases, namely: How often do you use health services? Do you depend financially on another person? What do you do when you feel sick? What advice would you give to someone your age to improve their health? Please, describe an experience. Data were analyzed following the four phases proposed by Leininger and McFarland (2006). The first phase consisted in reading the interviews exhaustively to become familiar with the data and select material for analysis – the *raw data* (Melguizo, 2012). In the second phase, the cultural descriptors were identified and categorized. The third phase involved the analysis of the categories and the identification of patterns that explained older adults' health-related behaviors. Finally, the fourth phase focused on the identification of the cultural theme that illustrates older adults' self-care behaviors which, based on their beliefs and perceptions, allow them to prevent, maintain, extend, restore, and/or recover their health or well-being. The analysis was dynamic and flexible to ensure feedback between each phase, thus avoiding a linear process. After their identification based on Leininger's culture care model, the self-care behaviors were evaluated in order to identify harmful behaviors to be adjusted and beneficial behaviors to be maintained or promoted.
The issues of credibility, auditability, completeness, and confirmability were taken into account to ensure rigor in data analysis. All ethical aspects were based on Article 17(1) of the General Health Law. In addition, the research study was approved by the Ethics Committee of the Center for Research in Medical Sciences of the Autonomous University of the State of Mexico (Registration No. 2014/02). All older adults signed the informed consent form after being explained about the purpose of the study. To ensure confidentiality, participants were identified using aliases suggested by them.

Results

A total of 17 older adults were interviewed (10 women and 7 men), who were aged 63 to 93 years. Men were the oldest participants (Table 1).

Table 1
Older adults' characteristics

Alias	Gender	Age	Marital status	Profession	Financial dependence	Medical conditions	Area of residence
Carlos	Male	72	Widower	Farmer	Independent	None	Rural area
Lucy	Female	64	Single	Homemaker	Dependent sons	Diabetes	Rural area
Beto	Male	74	Widower	Teacher	Independent	Diabetes, musculoskeletal injuries	Urban area
Jovita	Female	66	Separated	Businessperson	Independent	Depression, hypertension, migraine, pain	Urban area
Charly	Male	93	Married	Artisan	Independent	Prostatitis	Rural area
Adela	Female	63	Married	Homemaker	Dependent sons and husband	Rheumatoid arthritis	Rural area
Magaly	Female	66	Single	Businessperson	Independent	Diabetes, rheumatoid arthritis	Rural area
Gaby	Female	67	Married	Homemaker	Children and husband	Breast cancer, hypertension	Urban area
Eduardo	Male	67	Married	Businessperson	Independent	Diabetes, hypertension	Urban area
Pepe	Male	74	Married	Retired	Independent	Diabetes, hypertension	Urban area
Paty	Female	69	Widow	Homemaker pensioner	Independent	Hypertension, musculoskeletal injuries	Rural area
María	Female	63	Married	Homemaker	Dependent, husband	Depression	Rural area
Rosalba	Female	63	Separated	Businessperson	Independent	Hypertension, musculoskeletal injuries, colitis, gastritis	Urban area
Pilar	Female	74	Married	Homemaker	Dependent, children	Diabetes, hypertension, pelvic fracture	Rural area
Evelyn	Female	64	Widow	Pensioner	Independent	Rheumatoid arthritis	Urban area
Antonio	Male	71	Married	Farmer	Independent	Prostatitis	Rural area
Jesús	Male	69	Married	Farmer	Independent	None	Rural area

Source: Interviews.

A total of 24 categories were identified, which were divided into four patterns. In turn, these patterns served as basis for the following theme: In order to care for my health, I seek help when I feel very sick, but I also take care of myself by relaxing, eating properly, staying busy, protecting myself from harm, and avoiding excesses.

Explanatory patterns

First pattern - I keep my peace of mind through what I think, feel, and believe

This pattern integrates behaviors related to having positive thoughts, feelings, and emotions. Health-related self-care involves focusing on positive feelings and thoughts, based on the belief that "hatred and resentment are mostly what makes us sick" (Adela, May 2014). Older adults try not to give much importance to the difficulties or problems that they face on a daily basis. Older adults also tend to preserve their peace of mind by relying on a superior Being (God) or Saints to stay healthy, as well as to die peacefully, thanking and asking them for help, health, life, comfort, among other things: "in any case, we have to entrust ourselves, because it's God who decides if I'm going to die. I've already given myself to Him, because I live for Him and I believe in His will" (Charly, May 2014).

Second pattern - I watch my diet and pay attention not only to what I eat but also how I eat it

Dietary behaviors include ensuring the hygiene conditions to prepare food and eating fresh and natural products, believing that what is natural cannot be harmful, and maintaining an eating schedule. Older patients make a list of food products that they believe are harmful and forbidden by doctors. Thus, they tend to avoid fats, bread, eating too many *tortillas*, sweets, sugar, soda, meat (particularly pork), coffee, and *capeados* (bread-crusted food). In contrast, fruits, milk, vegetables, and beans were identified as healthy food. It should be noted that meat is considered to be harmful, which is a belief that must be readjusted.

Sometimes, older adults' behaviors cause distress within the family in result of the new eating habits:

> Then my daughter-in-law calls me unpleasant, because, no matter what they tell me . . . if I don't like it, I'm not going to eat it. Give me some nopales, some quelites, purslane, beans and you won't hear me complaining. (María, May 2014).

Third pattern - Staying busy is what keeps me going

Older adults believe that physical activity contributes to staying healthy, that their health deteriorates when they stop doing things. They find different ways of staying busy depending on their physical abilities, whether it is by working, exercising, doing activities at home, or helping the community. These behaviors make them feel healthy.

Although some older adults do not exercise at all, their daily routines show that they are very active at home, particularly women. Despite their illness and physical condition, they continue to do household activities such as sweeping, dusting, and cooking:

> I actually don't take care of myself, my daughter calls me a fool because I don't like to sit all day. I still clean the house, I wash the bed linen, the clothes, I cook, I do the housework, I makebreakfast. I don't sit down, although it's a big effort for me to walk. (Paty, May 2014)

For older adults, staying busy is not limited to the physical component; it is especially when they have less mobility and an increasing sedentary life that mental activity contributes to making them feel good: "because it entertains me (doing crafts), I do some things but they always come from here (pointing at the head). I think it's something that has helped me a lot." (Charly, May 2014).

Fourth pattern - Seeking help and helping myself

This pattern includes older adults' adjustments that reflect their decision-making and active participation, either by collaborating with other health care systems or, independently, by applying common knowledge. It includes being able to care for themselves, namely in case of a chronic disease, which is a behavior that nurses encourage and requires older adults' availability, commitment, and responsibility: "What helps me a lot is to participate here, with the nurses, in a program where there are conferences, talks, and everything related to nutrition. I've been doing it, trying to take care of myself" (Beto, May 2014).

Older adults identified other support networks, such as groups where they share self-care experiences. Furthermore, these groups are a form of socialization and group therapy that helps them by talking about their problems with others who have the same condition:

> A year ago, I joined the elderly group to get out of the house for a while,

because sometimes I felt very anxious, very desperate, . . . I come here, spend time with them, and feel more at peace." (Jovita, May 2014)

Older adults tend to follow the health professionals' recommendations. However, when they start feeling good, they sometimes change their medication regimen by stopping to take their medication or self-medicating, particularly by taking analgesics and muscle relaxants. This gives them a sense of autonomy and initiative in their treatment: "I try to stop taking sleeping pills because I want to see if I can fall asleep on my own, and stop depending so much on them." (Jovita, May 2014).

Older adults often display self-control behaviors based on the belief that the body can recover on its own: "I hold on, I hold on until I no longer feel sick . . . I don't think about it, I know I'm in control, I ignore it." (Beto, May 2014). These accounts reflect resistance behaviors based on willpower and testing the body limits. However, they also show health-related risk behaviors.

Older adults identified harmful agents, namely the air, water, cold, sunlight, medications, and alcohol, and protected themselves against them. For example, they do not shower often or only shower at night, they avoid getting wet when it is too cold, they try to keep themselves warm, and they avoid drafts and/or direct sunlight by wearing sunglasses. They also take their medication with milk to avoid stomach upset or change the dose: "Almost every time I shower, I do it at night and then I sleep under blankets because it opens our pores." (Carlos, May 2014).

Older adults also tend to *avoid excesses* based on the belief that *everything is good, but never too much*. This principle governs all their health-related behaviors, including their concern with achieving peace of mind, their diet, physical activity, medication, rest, alcohol, among others "Excess is another bad thing... It is physically exhausting . . . Everything is good, is normal, because it is . . . natural, right? But we have to deal with it." (Charly, May 2014).

The support of other people is essential and, although it is not a health-related behavior, it gives older people a sense of safety and protection, which, in turn, influences their well-being. "More than anything else, that there is someone to take care of us and knowing that we are safe with them. It is feeling safe" (Evelyn, May 2014).

Discussion

Health-related behaviors include caring for all dimensions of the human being (physical, mental, social, spiritual, and emotional), which suggests that older adults have a very broad and comprehensive concept of health.

Older adults living with disability and in poverty in Cartagena also cared for their thoughts, feelings, and beliefs (Melguizo, 2012), which also helped them to feel that they were not ill. On the other hand, older adults also reported that the trust in God and the Saints was an important form of support because it can be easily reached, it is free-of-charge, and strengthens their relationship with their family and friends. In Mexico, García, Cardoso, Serrano, and Ostiguín (2015) found that Catholic religious practices were part of the health culture. Spirituality has also been shown to influence the health status. According to Rodrigues (2011), when people are suffering after losing the meaning and the sense of life, spirituality represents a way of coping with grief, illness, and death, making them stronger in the face of adversity. This behavior comprises three components that, based on older adults' experiences, must be balanced: thoughts, feelings, and beliefs.

Health psychologists have extensively studied the influence of emotions, concluding that they can alter physiological processes and cause illnesses or coping difficulties.

With regard to diet, the results of this study are consistent with those reported by Orb (2004) in a study with older adults in Australia, who consider natural and home-cooked food to be healthier and meat to be unhealthy at their age. However, the results are not consistent with other studies conducted with older adults with poor appetite in Spain (Vadillo et al., 2012) and Germany (Van der, Wijnhoven, Finlayson, Oosten, & Visser, 2015), who preferred eating high-protein foods. Older adults' different perceptions of healthy food reflect the dietary diversity in each geographic context and the different concepts of

healthy food (Bisogni, Jastran, Seligson, & Thompson, 2012).

Older adults identified four types of food as harmful: salt, sweets or sugar, fats, and meat. The media and the health professionals have promoted the notion that some of these food products are harmful, which suggests that older adults follow health professionals' indications and recommendations. Older adults consider fruits, vegetables, and unprocessed foods as healthy. These data are in line with the studies conducted with Spanish (Vadillo et al., 2012) and English (Bisogni et al., 2012) older adults, who reported that staying healthy depends on eating fruits and vegetables.

Staying busy allows older people to be and feel functional, self-sufficient, and, consequently, healthy. It includes the performance of various activities, namely physical exercise at different intensities and frequencies depending on each person's availability, household activities, crafts or creative works, and physical work. It should be noted that physical activity should be adjusted to the physical abilities. Aldana, Fonseca, and García (2013) refer to it as *adjusted activity* and, even when not prescribed by a health professional, it should be noted that they match the physical medicine and rehabilitation physicians' recommendations, which include passive mobilization in order to maintain the physical function of frail and/or dependent older adults (Mikel et al, 2014; Vidarte, Quintero, & Beltrán, 2012), walking or jogging to increase their cardiac and respiratory rates, as well as high-impact or weight-bearing aerobic exercise to increase muscle strength, power, and mass (Aparicio, Carbonell, & Delgado, 2010).

Berenzon, Saavedra, and Alanís (2009) describe the practices that promote omitting or postponing health care as *self-control behaviors*, defining them as different ways of using willpower to feel symptoms, in other words, *holding on*, trusting in the ability of the body itself to overcome the crisis, based on the assumption that symptoms are transient. This risk behavior emphasizes the need to inform both older adults and family members or caregivers about the warning signs and symptoms. Melguizo (2012) has also reported these behaviors among poor and disabled older adults; however, in this case, the lack of resources to use medical services is one of the causes. The analysis of this behavior shows that older adults expose themselves to risk by postponing health care and relying on the body's ability to respond, which is an idea that must be demystified. According to the literature, as a person ages, disease processes that would have been easily solved in the past tend to worsen due to age-related physiological changes.

Melguizo and Castillo (2012) have described other factors that interfere with the use of preventive health services, namely financial factors, waiting times, and health condition. These aspects should be analyzed in further studies.

Some older adults were self-medicated, while others avoided taking any medication based on the belief that *too much medication is also harmful*. This behavior may affect or compromise their health in case of chronic disease management. Ruelas, Pelcastre, Ángeles, and Reyes (2012) also observed these behaviors, namely in the use of analgesics, which can be harmful due to their adverse events in older people. In Mexico, there is a lack of education on medication-related risks among older adults. In this sense, these beliefs could serve as basis for promotion interventions.

Other culture-based behaviors found in this study included the protection against physical agents, such as sun, cold, and air drafts, by keeping warm, avoiding going outside at certain hours of the day, wearing sunglasses, applying ointments for chills and rheumatic pain, wearing special protective clothing, among others. These behaviors are also evident in other contexts (Melguizo, 2012) and show older adults' initiative and creativity in self-care.

Older adults reported that they need help from others to stay healthy, which is a behavior that reflects the need to feel supported and trust in others – a support network. Family continues to be the main source of support, which is line with Pelcastre, Treviño, González, and Márquez (2011).

The self-regulation or restrictive behaviors through which older adults learned to avoid eating in excess, follow a meal schedule, get enough sleep, and avoid drinking alcohol and smoking reflect their life experiences to the

extent that they are aware of the consequences of the excesses in their youth. Melguizo (2012) also found similar behaviors among poor and disabled older adults, who reported that they avoid drinking alcohol and smoking, and that they eat, sleep, and do physical activities moderately.

For safety reasons, it was not possible to visit older adults at home, which limited the observation of behaviors and contextual aspects that could improve their description.

Conclusion

According to Leininger's culture care model, the self-care behaviors reported by the sampled older adults can be considered as health preservation or maintenance behaviors because they contribute to improving or maintaining a healthy life and coping with age-related changes. The risk behaviors identified include self-medication, self-control behaviors, and the identification of harmful food (particularly the reduction of protein intake). The sampled older adults display behaviors that are influenced by important physical, psychological, moral, and spiritual aspects at this stage of life. These behaviors put into evidence the combination of common knowledge and professional knowledge transmitted by health professionals, which leads to comprehensive health care that should be recognized by nurses, physicians, psychologists, among others, and integrated into self-care programs. Nurses should be aware of these behaviors in order to make informed decisions on how to deliver care to both community-dwelling and institutionalized older people.

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References

Aldana, G., Fonseca, H., & García, G. (2013). El significado de la vejez y su relación con la salud en ancianas y ancianos integrados a un programa de envejecimiento activo. *Revista Digital Universitaria, 14*(4), 1067-1079. Retrieved from http://www.revista.unam.mx/vol.14/num4/art37/index.html

Aparicio, V., Carbonell, A., & Delgado, M. (2010). Beneficios de la actividad física en personas mayores. *Revista Internacional de Medicina y Ciencias de la Actividad Física y del Deporte*, *10*(40), 556-576. Retrieved from http://www.redalyc.org/pdf/542/54222122004.pdf

Berenzon S., Saavedra N., & Alanís S. (2009). Estrategias utilizadas por un grupo de mujeres mexicanas para cuidar su salud emocional: Autoatención y apoyo social. *Salud Pública de México*, *51*(6), 465-473. Retrieved from http://www.scielo.org.mx/scielo.php?script=sci_arttext&pid=S0036-36342009000600005&lng=es&tlng=es

Bisogni, C., Jastran M., Seligson M., & Thompson, A. (2012). How people interpret healthy eating: Contribution of qualitative research. *Journal of Nutrition, Education and Behavior, 44*(4), 282-301. doi:10.1016/j.jneb.2011.11.009.

García, P., Cardoso, M., Serrano, C., & Ostiguín, M. (2015). Prácticas de cuidado tradicional y espiritual en una comunidad indígena nahua. *Revista de Enfermería y Humanidades: Cultura de los Cuidados*, *19*(41), 34-43. doi:10.14198/cuid.2015.41.06

González, C., Sánchez, S., Juárez T., Rosas, O., Gutiérrez, L., & García, C. (2011). Health care utilization in the elderly Mexican population: Expenditures and determinants. *BMC Public Health, 11*, 192. doi:10.1186/1471-2458-11-192

Hernández Zambrano, S. M., Hueso Montoro, C., Montoya Juárez, R., Gómez Urquiza, J. L., & Bonill de las Nieves, C. (2016). Metaestudio cualitativo sobre vivencias y gestión del cotidiano en adultos mayores que padecen enfermedades crónicas. *Revista de Enfermería y Humanidades: Cultura de los Cuidados, 20*(44), 75-90. doi:10.14198/cuid.2016.44.07

Leininger, M., & McFarland, M. (2006). *Cultural care diversity and universality: A worldwide nursing theory*. Sudbury, MA: Jones and Bartlet.

Melguizo, H. (2012). *Cultura del cuidado de la salud*. Colombia: Universidad de Cartagena.

Melguizo, H., & Castillo, I. (2012). Factores asociados al uso de los servicios de atención primaria por adultos mayores de Cartagena, Colombia. *Revista de Salud Pública, 14*(5), 765-775. Retrieved from http://www.scielosp.org/pdf/rsap/v14n5/v14n5a04.pdf

Menéndez, E. (2005). Intencionalidad, experiencia y función: La articulación de los saberes médicos. *Revista de Antropología Social*, *14,* 36-69. Retrieved from http://www.redalyc.org/pdf/838/83801402.pdf

Mikel I., Cadore, E., & Casas, A. (2014). Ejercicio físico en el anciano frágil: Una manera eficaz de

prevenir la dependencia. *Kronos*, *13*(1). Retrieved from https://g-se.com/ejercicio-fisico-en-el-anciano-fragil-una-manera-eficaz-de-prevenir-la-dependencia-1702-sa-l57cfb27242418

Orb, A. (2004) Aspectos de salud en adultos mayores de 80 años de edad que viven independientemente en la comunidad: Una perspectiva australiana. *Revista Latino-Americana de Enfermagem*, *12*(4), 589-596. doi:10.1590/S0104-11692004000400003

Pelcastre, B., Treviño, S., González, T., & Márquez, M. (2011). Apoyo social y condiciones de vida de adultos mayores que viven en la pobreza urbana en México. *Cadernos de Saúde Pública*, *27*(3), 460-470. doi:10.1590/S0102-311X2011000300007

Purnell, L. (1999). El modelo de competencia cultural de Purnell: Descripción y uso en la práctica, educación, administración e investigación. *Revista de Enfermeria y Humanidades: Cultura de Cuidados*, *3*(6), 91-102. doi:10.14198/cuid.1999.6.13

Rodrigues, A. M. (2011). La espiritualidad ante la proximidad de la muerte…. *Enfermería Global*, *10*(2), 1-8. Retrieved from http://www.redalyc.org/articulo.oa?id=365834766020

Ruelas, G., Pelcastre, V., Ángeles, L., & Reyes, M. (2012). Medicamentos para adultos mayores: Percepciones y adquisición en farmacias privadas de Morelos, México. *Revista Chilena de Salud Pública, 16*(2), 146-155.

Vadillo, V., González, J., López, M., Zarrabeitia, I., & Pérez, C. (2012). Preferencias alimentarias en personas mayores de 60 años. *Revista Española de Nutrición Comunitaria, 8*(3-4), 113-117.

Van der, S., Wijnhoven, H., Finlayson, G., Oosten, B., & Visser, M. (2015). Specific food preferences of older adults with a poor appetite: A forced-choice test conducted in various care settings. *Appetite, 90*, 168-175. doi: 10.1016/j.appet.2015.03.011

Vidarte, J., Quintero, M., & Beltrán, Y. (2012). Efectos del ejercicio físico en la condición física funcional y la estabilidad en adultos mayores. *Revista Hacia la Promoción de la Salud*, *17*(2), 79-90. Retrieved from http://www.redalyc.org/articulo.oa?id=309126826006