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Original Article

PARTICIPATION IN GROUP AS A RESOURCE FOR HEALTH PROMOTION AND QUALITY OF LIFE AMONG OLDER PEOPLE

PARTICIPAÇÃO EM GRUPO COMO RECURSO PARA PROMOÇÃO DA SAÚDE E QUALIDADE DE VIDA ENTRE IDOSOS

PARTICIPACIÓN EN GRUPO COMO RECURSO PARA LA PROMOCIÓN DE LA SALUD Y LA CALIDAD DE VIDA EN LAS PERSONAS MAYORES

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Objective: to analyze participation in health promotion group meetings as a strategy to improve quality of life among older people. Method: this was a cross-sectional, analytical and prospective study. Data were collected using an instrument including sociodemographic question, WHOQOL-BREF, and WHOQOL-OLD. We used the Stata software version 11.0 to analyze data using the multiple linear regression. Level of significance adopted was ≤ 5%. Results: to participate in a group was significantly associated with higher score in quality of life in the following domains "physical", "social relations", "enviroment" (WHOQOL-BREF), and facets "pass, present and future activities", "social participation" (WHOQOL-OLD). Conclusion: the health promotion group meetings improved many aspects of life of older people, especially related to social inclusion and establishment/maintencare of an interpersonal relationship.

Descriptors: Quality of life. Group structure. Health promotion.

Objetivo: analisar a participação em grupo de promoção da saúde como estratégia para melhorar a qualidade de vida de idosos. Método: estudo transversal, analítico e prospectivo. Os dados foram coletados por meio de um instrumento com questões sociodemográficas e pelos WHOQOL-BREF e WHOQOL-OLD, e analisados no software Stata versão 11.0, por meio de regressão linear múltipla. O nível de significância adotado foi ≤ 5%. Resultados: participar do grupo foi significativamente associado a melhores escores de qualidade de vida nos domínios "físico", "relações sociais" e "meio ambiente" (WHOQOL-BREF), e nas facetas "atividades passadas, presentes e futuras" e "participação social" (WHOQOL-OLD). Conclusão: a participação em grupo de promoção da saúde favorece melhorias em diversos aspectos da vida dos idosos, especialmente os relacionados à inclusão social e ao estabelecimento/manutenção de relacionamento interpessoal.

Descritores: Qualidade de vida. Estrutura de grupo. Promoção da saúde.

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Objetivo: conocer la participación en las reuniones del grupos de promoción de la salud como estrategia para mejorar la calidad de vida de las personas mayores. Método: se trata de un estudio transversal, analítico y prospectivo. Los datos se recolectaron utilizando un instrumento que incluía una pregunta sociodemográfica, WHOQOL-BREF y WHOQOL-OLD. Utilizamos la versión 11.0 del software Stata para conocer datos utilizando la regresión lineal múltiple. El nivel de significación fue ≤ 5%. Resultados: participar en un grupo se asoció significativamente con mayor puntuación en calidad de vida en los siguientes ámbitos "físico", "relaciones sociales", "medio ambiente" (WHOQOL-BREF) y facetas "paso, actividades presentes y futuras" "Participación social" (WHOQOL-OLD). Conclusión: las reuniones de grupos de promoción de la salud mejoraron muchos aspectos de la vida de las personas mayores, especialmente relacionadas con la inclusión social y el establecimiento / mantenimiento de una relación interpersonal.

Descriptores: Calidad de vida. Estructura de grupo. Promoción de la salud.

Introduction

The health care group intervention has been employed worldwide as a resource for health assistance because it contributes for socialization, changes in life habits and learning[1]. In Brazil, this practice is recommended by Brazil's Ministry of Health (MH) and it is broadly employed in primary care[2-3].

However, studies indicate that care group intervention does not achieve all its potential[4-5], and it has not collaborated to improve quality of life (QL) of participants[6]. A number of authors suggest that non-efficacy of group interventions can be because of adopted structure and function that not always consider needs of subjects due to the emphasis given only to aspects related to diseases[2,4-5].

We observe that cluster of people are called wrongly and commonly as groups. However, only gather a determined the number of subjects is not enough to consider a group. A group should show, among other aspects, the construction of authentic interpersonal relationships and permanent process of reciprocity among participants[7-8].

In addition to concept of error, to consider a group when it is not, we observe a worrying process of banalizing the implementation and conduction of group interventions in health area, in a clearly technical perspective, given the false impression that coordinate groups is simple task and does not require theoretical knowledge, but only knowledge about some games and techniques, commonly applied without be considered real needs for people involved in this activity[8].

To achieve a more assertive group care, to acquire knowledge about group dynamic is paramount. This expression is related to study nature of group and role of coordinator, as well as functioning, basic movements and interactions among members of the group[7].

After acquisition of new knowledge and skills, coordinators of a group have the possibility for great autonomy and ability to innovate, which can strengthen the use of group as a transforming tool to seek changes in the behavior and coping strategies[2,8].

This study analyzed participation of older people in health promotion group intervention as a strategy to improve QL among this population. The hypothesis was that to participate of health promotion group meetings that address group dynamic needs influence positively a number of aspects of people's live and, consequently, favor a better QL score.

Method

This was a cross-sectional, analytical and prospective study carried out in Primary Health Care Unit for Family (UABSF) in the municipality of Goiania, Goiás State, Brazil. The specific health care unit was chosen because of partnership between the university and the service, considering that UABSF is the teaching scenario for theory and practical activities of the high education institution in which researches

of this study are affiliated. Therefore, results of this study would collaborate to implement strategies directed to address the real needs of older population, and redirect practice of group activity in a manner that care is not based on indiscriminate use of techniques and strategies, but in experiences sharing, valorization of the individual and humanization of care.

The age of studied population was ≥ 60 years, registered in the health unit totalizing 602. This study, by convenience, the sample was composed by 116 elderlies distributed into two groups, G1 and G2. The first, G1 was composed by 26 participants of a group of health promotion that was part of UABSF. The G2 was composed by 90 elderlies who received health care in the period of data collection, but who did not participated in group activities.

The group of health promotion of UABSF had more than twelve years of existence and it is coordinated by Health Community Agents (HCA). The group promotes activities such as stretching, painting, dancing, games, presentation of poems and music. There is low rate of evasion and permanent renovation of proposed activities without the bound with member to be related, necessarily, with a benefit as offering of medicines, consultations and others.

Meetings occur weekly lasting for three hours and it focuses on attention for health promotion among elderlies. Each group session is organized to include phases of embracement, perform of tasks, group process experience and, at the end of each meeting, activities are evaluated. These actions address presupposes of group dynamic[8-9].

Data collection occurred from June to October 2012 by using three instruments: sociodemographic questionnaire, WHOQOL-BREF and WHOQOL-OLD. Questionnaires were applied by responsible researcher and by five research assistants.

Participants of this study were aged ≥ 60 years, registered in the investigated UABSF, mentally oriented and able to communicate verbally. Among elderlies of health promotion group, we excluded those with discontinued participation, with less than two monthly presences.

Exposition variables of this study were: participation in health promotion group, age, sex, formal education, live alone, live with partner, number of individuals in the same house, receive government retirement financial assistance, individual income, contribute with family expenses and type of home. Endpoint variables were score obtained in domains of WHOQOL-BREF (physical, psychological, social relations and environment) and facets of WHOQOL-OLD (sensorial skills, autonomy, pass, present and future activities, social participation, death and die, and intimacy).

Score of QL in each one of the four domains of WHOQOL-BREF and six facets of WHOQOL-OLD, indicated perception of elderlies to satisfaction in a number of aspects of their lives. According to scale used in the study, from 0 to 100, the highest the score obtained, the positive the perception of QL.

Data were analyzed using the Stata software version 11.0. We did descriptive statistics for characterization of elderlies and each domain of WHOQOL-BREF and facet of WHOQOL-OLD, we were represented by means, standard deviation and respective confidence interval.

The WHOQOL-BREF and WHOQOL-OLD were tested when reliability by analysis of internal consistence, using the Cronbach's alpha. We used the multiple linear regression to identify associated factors to each domain of WHOQOL-BREF and facet of WHOQOL-OLD. The strategy used in modeling was stepwise forward in which we included, in multiple analyses, variables of exposition that obtained a value of p≤ 0.20 in bivariated and variable participation in the group, regardless of p value. We kept the model to variables that obtained an adjust in estimator of, at least, 10% or those with p≤ 0.05 value.

This study was approved by Ethical and Research Committee at Hospital das Clínicas at Universidade Federal de Goiás, protocol number 036/2011.

Results

Cronbach's alpha result in domains of WHOQOL-BREF ranged from 0.73 to 0.88 and in facets of WHOQOL-OLD from 0.76 to 0.80 (Table 1).

Table 1 – Internal consistence of domains of WHOQOL-BREF and facets of WHOQOL-OLD. Primary Health Care Unit for Family of East Sanitary District. Goiania, Goiás, Brazil, 2012. (N=116)

Quality of life	Cronbach's Alpha
WHOQOL-BREF	
Physical	0.88
Psychological	0.82
Social relations	0.73
Environment	0.77
WHOQOL-OLD	
Sensorial skills	0.78
Autonomy	0.76
PPF activities	0.78
Social participation	0.80
Death and die	0.80
Intimacy	0.80

Source: Created by the authors.

Elderlies mean age of G1 is 71.0 years (SD=7.2) a for those that integrate G2 is 70.6 (SD=6.9). The majority of women in two groups (G1: 22, G: 76) as well as elderlies that did not live alone (G1: 22, G2: 79). Exactly half of individuals of G2 did not live with partner (45.50%), situation observed in more than half of individuals in G1 (15, 57.7%). Most of elderlies did have low individual income and low education, and 88 contributed with family expenses (G1: 21; G2: 67) (Table 2).

Table 2 – Differences between sociodemographic and economic characteristics of elderlies registered in the Primary Health Care Unit for Family of East Sanitary District who participated and not participated in health promotion group. Goiânia, Goiás, Brazil, 2012 (to be continued)

Characteristics	Group participation		p
	Yes f (%)	No f (%)	
Age – years, mean (Standard Deviation)*	71.0 (7.2)	70.6 (6.9)	0.809
Sex (N=116)			
Male	4 (15.4)	14 (15.6)	
Female	22 (84.6)	76 (84.4)	
Formal education (N=115)			0.026
≤4 years	18 (69.2)	78 (87.6)	
>4 years	8 (30.8)	11 (12.4)	
Live with a partner (N=116)			0.489
No	15 (57,7)	45 (50.0)	
Yes	11 (42,3)	45 (50.0)	
Live with			0.848
Children and/or grandchildren	11 (42.3)	31 (34.5)	
Partner, children and/or grandchildren	6 (23.1)	24 (26.7)	
Only partner	4 (15.4)	19 (21.1)	
Alone	4 (15.4)	11 (12.2)	
Partner and other relatives	1 (3.8)	2 (2.2)	
Other relatives	0 (0.0)	3 (3.3)	

Table 2 – Differences between sociodemographic and economic characteristics of elderlies registered in the Primary Health Care Unit for Family of East Sanitary District who participated and not participated in health promotion group. Goiânia, Goiás, Brazil, 2012 (conclusion)

Characteristics	Group participation		p
	Yes f (%)	No f (%)	
People living in the same house (N=116)			0.888
No more than two	10 (38.5)	36 (40.0)	
Three or more	16 (61.5)	54 (60.0)	
Government retirement finance assistance (N=116)			0.156
No	9 (34.6)	19 (21.1)	
Yes	17 (65.4)	71 (78.9)	
Individual Income (N=113)			0.694
≤1 minimal wage	20 (76.9)	70 (80.5)	
>1 minimal wage	6 (23.1)	17 (19.5)	
Contribute with family expenses (N=116)			0.507
No	5 (19,2)	23 (25.6)	
Yes	21 (80,8)	67 (74.4)	
Family income (N=103)			0.406
≤1 minimal wage	7 (33,3)	20 (24.4)	
>1 minimal wage	14 (66,7)	62 (75.6)	
Type of house (N=116)†			0.548
Rented	1 (3.9)	3 (3.3)	
Own	25 (96.1)	83 (92.2)	
Other	0 (0.0)	4 (4.5)	
Total	26 (22.4)	90 (77.6)	

Source: Created by the authors.

* Student T test. † Fisher's test.

In the analysis of socioeconomic and demographic aspects of Table 2, we observed that formal education (p=0.026) and number of persons who contributed with family expenses (p= 0.012), were conditions that presented statistical difference between groups G1 and G2. In elderlies who integrated the group G1, there was higher proportion of individuals with formal education for more than four years and only one person contributed with family expenses.

The majority of elderlies of G1 evaluated their QL as good or very good (20, 76.9%), but almost all of them were not satisfied with their health (24, 92.4%). Of 90 elderlies from G2, 52 (57.78%) evaluated their QL as good or very good and, participants of G1, 68 (75.56%) were also satisfied with their health (Table 3).

Table 3 – Differences between general evaluation of quality of life and satisfaction with health of elderlies registered in Primary Health Care Unit for Family of East Sanitary District who participated or not participated in a group of health promotion. Goiânia, Goiás, Brazil, 2012. (N=116) (to be continued)

Questions	G1 f (%)	G2 f (%)	P
How do you evaluate your quality of life?			0.046
Very poor	0 (0.0)	2 (2.2)	
Poor	0 (0.0)	7 (7.8)	
Nor poor neither good	6 (23.1)	29 (32.2)	
Good	14 (53.8)	47 (52.2)	
Very good	6 (23.1)	5 (5.6)	

Table 3 – Differences between general evaluation of quality of life and satisfaction with health of elderlies registered in Primary Health Care Unit for Family of East Sanitary District who participated or not participated in a group of health promotion. Goiânia, Goiás, Brazil, 2012. (N=116) (conclusion)

Questions	G1 f (%)	G2 f (%)	P
In what extent are you satisfied with your health?			0.026
Very insatisfied	6 (23.0)	4 (4.4)	
Insatisfied	12 (46.1)	40 (44.4)	
Nor satisfied neither insatisfied	6 (23.1)	24 (26.7)	
Satisfied	2 (7.8)	20 (22.2)	
Very satisfied	0 (0.0)	2 (2.2)	
Total	116	100	

Source Created by the authors.

We observe in Table 3 that no participant of the group G1 perceived their QL as poor or very poor. A different situation was seen by elderlies of group G2 who 9 (10%) indicated the QL such as poor or very poor. Whereas 20 (22.2%) of elderlies in group G2 showed satisfaction with their health, only 2 (7.8%) of individuals of G1 had a similar opinion. Most of elderlies of this study were not satisfied with their health, however, more than half evaluated positively their QL, mentioning it as good or very good.

Elderlies who participate in the group G1 had most of mean score of QL in all domains of WHOQOL-BREF. We observe that only in psychological domain this result was not statistically significant. The higher score for group G2 in WHOQOL-BREF was obtained in domain "social relation" (69.5; SD= 11.6) and lower, in the "environment" (50.5; DP= 12.2) (Table 4). Elderlies of G1 had higher mean score and statistically significant in facets "PPF activities" (G1: 69.7 and SD= 11.7; G2: 59.2 and SD= 15.0), "social participation" (G1: 72.4 and SD= 11.2; G2: 55.6 and SD= 16.3) and total score (G1: 87.5 and SD= 7.9; G2: 82.8 and SD= 10.8) of WHOQOL-OLD (Table 4).

Table 4 – Differences among quality of life scores registered in Primary Health Care Unit for Family of East Sanitary District of participants and non-participants of the health promotion group. Goiânia, Goiás, Brazil, 2012. (N=116)

Quality of life	G1		G2		P
	Mean (Standard deviation)	95% confidence interval	Mean (Standard deviation)	95% confidence interval	
WHOQOL-BREF (0-100 score)					
Physical	66.7 (11.2)	62.4 – 71.1	56.8 (14.3)	53.9 – 59.9	0.002
Psychological	67.9 (11.2)	63.6 – 72.3	61.8 (15.9)	58.5 – 65.2	0.079
Social Relations	75.3 (15.4)	69.3 – 81.3	69.5 (11.6)	67.1 – 71.9	0.041
Environment	60.2 (11.2)	55.7 – 64.7	50.5 (12.2)	47.9 – 53.1	0.000
WHOQOL-OLD (0-100 score)					
Sensorial skills	70.0 (18.1)	62.5 – 77.5	69.4 (19.3)	65.4 – 73.7	0.449
Autonomy	58.4 (14.9)	52.6 – 64.2	58.8 (13.7)	55.9 – 61.6	0.839
PPF activities	69.7 (11.7)	65.0 – 74.4	59.2 (15.0)	56.1 – 62.4	0.001
Social participation	72.4 (11.2)	67.8 – 76.9	55.6 (16.3)	52.2 – 59.0	0.000
Death and die	56.7 (19.5)	48.8 – 64.6	55.4 (23.5)	50.3 – 60.4	0.394
Intimacy	67.3 (20.3)	59.4 – 75.2	67.7 (15.0)	64.6 – 70.8	0.653
Total score	87.5 (7.9)	84.2 – 90.7	82.8 (10.8)	80.4 – 85.2	0.049

Source: Created by the authors.

Participation in a health promotion group and three individuals or more who live in the same house reflected positively QL of elderlies. However, age, contribute with family expenses, live alone and individual income of less than one minimal wage presented the negative additional in QL of this population (Table 5 and 6). The participation in health promotion group was positively associated with scores obtained in "physical", "social relation", and "environment" domains and in facets "pass, present and future activities" and "social participation" (Tables 5 and 6).

Table 5 – Associated factors to WHOQOL-BREF domains. Primary Health Care Unit for Family of East Sanitary District. Goiânia, Goiás, Brazil, 2012. (N=116)

WHOQOL-BREF domains/ Independent variables	**βaj**	**P**
Physics (r^2=0.24; p=0.000)		
Participation in a group	8.84	0.002
Age	-0.56	0.002
Contribution with family expenses	-10.03	0.001
Formal education (> 4 years)	3.26	0.336
Numbers of individuals at home (≥ 3)	6.02	0.015
Psychological (r^2=0,04; p=0,08)		
Participation in a group	5.15	0.139
Individual income ≤ 1 minimal wage	-4.20	0.256
Contribution with family expenses	-3.67	0.290
Formal education (> 4 years)	3.86	0.368
Age	0.25	0.254
Social relations (r^2=0,10; p=0,003)		
Participation in a group	5.86	0.033
Live alone	- 8.55	0.014
Age	-0.29	0.083
Government retirement finance assistance	2.23	0.424
Environment (r^2=0.15; p=0.000)		
Participation in a group	8.76	0.002
Formal education (> 4 years)	4.32	0.186
Individual income ≤ 1 minimal wage	-5.98	0.039
Live alone	4.07	0.220

Source: Created by the authors.

βaj: adjusted coefficient.

Table 6 – Associated factors to WHOQOL-OLD domains. Primary Health Care Unit for Family of East Sanitary District. Goiânia, Goiás, Brazil, 2012. (N=116) (to be continued)

Facets of WHOQOL-OLD/ Independent variables	**βaj**	**p**
Sensorial skills (r^2=0,12; p=0,001)		
Participation in a group	-0.12	0.976
Age	-0.83	0.002
Live with a partner	4.49	0.188
Formal education (> 4 years)	5.35	0.278
Autonomy (r^2=0,07; p=0,020)		
Participation in a group	-0.09	0.855
Individual income ≤ 1 minimal wage	-1.24	0.019
Contribution with family expenses	-0.96	0.079
Government retirement finance assistance	-0.13	0.810

Table 6 – Associated factors to WHOQOL-OLD domains. Primary Health Care Unit for Family of East Sanitary District. Goiânia, Goiás, Brazil, 2012. (N=116) (conclusion)

Facets of WHOQOL-OLD/ Independent variables	βaj	p
Pass, present, future activities (r^2=0.10; p=0.001)		
Participation in a group	10.06	0.002
Live with a partner	-4.66	0.083
Social participation (r^2=0.19; p=0.000)		
Participation in a group	16.28	0.000
Age	-0.53	0.017
Contribution with family expenses	-2.89	0.441
Individual income ≤ 1 minimal wage	-1.72	0.515
Live alone	2.97	0.542
Death and die (r^2=0.003; p=0.044)		
Participation in a group	1.72	0.738
Individual income ≤ 1 minimal wage	-11.48	0.031
Intimacy (r^2=0.02; p=0.679)		
Participation in a group	0.96	0.851
Number of individuals at home (≥3)	5.29	0.235
Live with a partner	-4.17	0.360
Sex (female)	-1.54	0.801

Source: Created by the authors.

βaj: adjusted coefficient.

Discussion

The increase number of elderlies is a great achievement of humans that, not always, is followed by adequate housing condition, dignity, well-being and QL in this population[9].

A number of factors can turn aging a difficult experience. The low formal education, for example, can affect negatively the QL of elderlies[10], and cause harm to access to health education activities[11], strategies that enable the adoption of health behaviors and social mobilization for improvement of life conditions[2,11].

Lack of finance resource can also interfere in decision making, autonomy and life management of an elderly[12]. Social and economic circumstances determine inequality in life and work conditions to elderlies, in addition to inadequate access to food, housing, education, among other factors, influencing and corroboration to exposition of these individuals to different vulnerability situations[11].

In general, aging is complex phenomena. Changes because of this process, such as appearance of chronic-degenerative disease and physical-functional limitations and/or cognitive can limit the health of elderlies, causing them, most of the times, insatisfaction with this aspect of life[13].

In addition, the management of health, presence of symptoms and changes in daily routine, can influence negatively the perception of QL of people[14]. Elderlies with pain and discomfort, sleep disorders and changes in mobility, dependency in the use of medicines and need of treatment, for example, present a worsening in QL compared with elderlies that do not present the same characteristics[15].

However, as observed in this study and in other, the insatisfaction with health does not necessarily mean insatisfaction with QL. Even elderlies with a number of comorbidities can show positive perception concerning QL[16]. For many individuals, a controlled diseased and/or use of medicines do not make them perceive themselves as sick.

A study including 264 elderlies revealed that, despite the presence of comorbidities in 82.2% of interviewers, most of them was satisfied with its QL. This result can be associated with the fact that these individuals have an active ageing process. They participate in community activities and, in addition, they perform any type of unpaid work[16]. These finding reinforce the multidimensional activities of QL and that it does not limit the fact of be healthy, but it also evolve culture, economic and psychosocial aspects.

Authors suggest that implementation of health promotion programs directed to healthy aging represent a strategy to contribute for improvement of QL and health of elderlies, because such programs stimulate social participation, interaction, and empowering of these subjects[17]. In addition, they can favor maintenance of healthy life style and social inclusion, and also active aging[18].

Social isolating is both important for mortality rates and for presence of chronic problems to the health of the elderly. The feeling of no one to count on represents a great risk for health of this population[19].

Aging process, although causing drop of some cognitive abilities, can be compensated if the elderly maintain active within the community, therefore establishing support networks. For this reason, comprehension is a determinant for QL of elderlies, in addition to biologic aspects, as well as possibilities to establish a interpersonal relationship and social participation[16].

Participation in a group is a manner that elderlies can return to social living. The inclusion in groups occur for several reasons, such as reduction of aloneness, possibility to do leisure activities, living with other elderlies, feeling of freedom, will to live and, consequently, improvement of QL[20].

We highlight that QL and participation in groups are important determinants for active aging[18]. To participate in health promotion groups can contribute to strengthen someone's control in his/her social environment, and favor autonomy and development of behaviors for continuous transformation of level of health and life conditions[19].

To the elderlies, to be part of groups do not mean only to experience educative practice, but also work collectively, be part of discussion and alterative proposal, actions planning, achievement of planning, control and evaluation of activities. The involvement in the community collaborate significantly to improve perception of personal reliability and satisfaction in living[21].

Elderlies, when no stimulated, without objectives in life o when not involved with pleasure activities can be feel isolated and without motivation and they may present an compromised emotional status[22]. For this reason, life in a group gives the opportunity to the elderlies feel useful because they can help others who are experience similar situations as them, even, more difficult than theirs. This experience promotes personal valorization[4,19].

The feeling to help the other is more important to elderlies because it cause them a feeling of being productive, able to take care and be important to others. This situation cooperates positively to elderlies health status and QL[23].

A study[24] revealed that elderlies participating in living group, even with higher prevalence of diseases, had better score of QL compared with elderlies who did not participate in groups. The group contributes to improve perception of health status and maintenance of adequate levels of physical activity, therefore the group is a protective factor for health of elderlies, in addition group bring benefits in functional independency and better perception to elderlies' QL.

Of note is that someone who are not sedentary has reduction of up to 40% in risk of death for cardiovascular diseases and, when physical activity is associated with adequate diet, this reduction can reach up to 58% the risk of diabetes type II progression. Therefore, the change in behavior can provoke a massive improve in health of elderlies[25].

Elderlies have wishes, plans to the future, love needs, need a partner and sexual desire. Those who are more participative in the

community who exercise regularly and keep social participation are more satisfied with life[16].

Groups are new alternatives and possibilities for human development. Groups constitute a place for valorization and empowering of elderlies, and a tool for seek new opportunities for their life and a healthy aging[2,4].

This study limitations include the impossibility to establish relationship of causality among variables, the cross-section approach applied, the need of include more variable in future investigations to identify other factors that can influence positively or negatively the QL among older population.

Conclusion

To participate in health promotion group was statically associated with higher score of QL in following domains "physical", "social relations", "environment" (WHOQOL-BREF) and in facets "pass, present and future activities" and "social participation" (WHOQOL-OLD). The results showed that groups really contribute for improvement of QL among elderlies.

Groups of health promotion have a great potential to reduce felling of sadness and social isolation, commonly feeling among older population. Therefore, this resource can be used by health professionals to promote and protect health of elderlies.

Of note is that activities developed within the studied group fulfill the requirements for group dynamic, i.e., actions are determined by needs of elderlies and they are planned to enable construction of bound between coordinators and members of the group. These characteristics can strengthen benefits of group practice on QL of elderlies.

Collaborations

1. conception of the project, data analysis and interpretation: Leidiene Ferreira Santos, Lizete Malagoni de Almeida Cavalcante Oliveira, Maria Alves Barbosa, Ruth Minamisava, Brenda Nogueira de Souza and Daniella Pires Nunes;

2. drafting the manuscript, critical review relevant for the intelectual content: Leidiene Ferreira Santos, Lizete Malagoni de Almeida Cavalcante Oliveira and Daniella Pires Nunes;

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