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Quality of life assessment for health promotion groups

Qualidade de vida para avaliação de grupos de promoção da saúde

Calidad de vida para evaluación de grupos de promoción de la salud

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ABSTRACT

Objective: to analyze the use of quality of life assessment (QOL) as a strategy to evaluate the work with health promotion groups in the community. **Method**: cross-sectional, descriptive and analytical study. Participants of two elderly groups (n = 46) were individually interviewed to fill the sociodemographic instruments, WHOQOL-BREF and WHOQOL-OLD. **Results**: the participants were women with up to 79 years, who did not live with a partner, with up to four years of study, retired, with individual income of up to a minimum salary. The mean scores on the WHOQOL-BREF were higher on "Social Relations" and lower in the "Environment". For the WHOQOL-OLD, the highest scores were achieved in facets "Social Participation" (G1) and "Past, Present and Future Activities" (G2), while "Death and Dying" facet obtained lower scores in both groups. **Conclusion**: the assessment of QOL appears to be useful in helping to identify the coordination aspects of life of elderly people that need to be better developed in groups.

Key words: Group Processes; Health Promotion; Quality of Life, Elderly.

RESUMO

Objetivo: analisar o uso da avaliação da qualidade de vida (QV) como estratégia para avaliar o trabalho com grupos de promoção da saúde na comunidade. **Método**: estudo transversal, descritivo e analítico. Participantes de dois grupos de idosos (n = 46) foram entrevistados individualmente para preenchimento dos instrumentos de caracterização sociodemográfica, WHOQOL-BREF e WHOQOL-OLD. **Resultados**: predominaram mulheres, com até 79 anos, que não moravam com companheiro, estudaram até quatro anos, aposentadas, com renda individual de até um salário mínimo. Os escores médios no WHOQOL-BREF foram mais elevados no domínio "Relações Sociais" e mais baixos em "Meio Ambiente". No WHOQOL-OLD, os maiores escores foram atingidos nas facetas "Participação Social" (G1) e "Atividades Passadas, Presentes e Futuras" (G2), enquanto a faceta "Morte e Morrer" obteve menores escores nos dois grupos. **Conclusão**: a avaliação da QV mostrou-se útil para ajudar a coordenação a identificar aspectos da vida dos idosos que precisam ser melhor trabalhados nos grupos.

Descritores: Processos Grupais; Promo**ção da Saúde; Qualidade de Vida;** Idoso.

RESUMEN

Objetivo: analizar el uso de la evaluación de calidad de vida (CV) como estrategia para evaluar el trabajo realizado con grupos de promoción de la salud en la comunidad. **Método**: estudio transversal, descriptivo y analítico. Los participantes de dos grupos de personas mayores (n = 46) fueron entrevistados de manera individual para completar los instrumentos de caracterización sociodemográfica WHOQOL-BREF y WHOQOL-OLD. **Resultados**: predominaron mujeres de hasta 79 años que no convivían con ningún compañero, con hasta cuatro años de estudios, jubiladas, con ingresos individuales equivalentes al salario mínimo. En WHOQOL-BREF la puntuación más alta se registró en "Relaciones Sociales" y la más baja en "Medio Ambiente". En

WHOQOL-OLD, las puntuaciones más altas se registraron en los apartados de "Participación Social" (G1) y "Actividades Pasadas, Presentes y Futuras" (G2), mientras que el apartado "Muerte y Morir" obtuvo las puntuaciones más bajas en los dos grupos. **Conclusión**: la evaluación de CV resultó útil para coordinar e identificar los aspectos de la vida de personas mayores que necesitan de un desarrollo más profundo en los grupos.
Palabras clave: Procesos Grupales, Promoción de la Salud, Calidad de Vida; Personas Mayores.

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INTRODUCTION

The use of a group to care for patients in medicine has shown great utility and efficiency in education and health promotion, since it enhances the understanding of the individual over the health-disease process and consequently favors changes in lifestyle habits that constitute a health risk[1-2]. Group assistance is a recommended procedure by the Brazilian Ministry of Health to work with different populations, including the elderly[3], whose significant growth has been demanding greater attention from Brazilian managers for public health policies aimed at this population[4].

Population aging is a global phenomenon[3-4], and in this period of human life, the occurrence or complication of several chronic diseases that require continuous treatment and may lead in functional disabilities is common[5]. However, aging can be associated with a good level of health when combined with adequate disease prevention and health promotion strategies[6]. Therefore, there is great public sector investment in primary care for the elderly, with an emphasis on active and healthy aging[3].

In this context, the group activity is highlighted as a valuable instrument to assist the elderly in primary health care. Participation in groups helps to reduce social isolation and improve adherence to therapeutic approaches, contributing to the promotion of active aging and thus, improve the quality of life of the elderly[7-8].

To be considered effective, the group must follow the basic principles of group dynamics[9]. Therefore, it is essential that the group coordinators know the real needs of its members in order to plan activities that will allow their satisfaction. To make sure that the group is meeting their objectives, it is essential to assess the strategies used in its development regularly[10]. This assessment can be done from the perspective of its coordinators, but it is essential to also take into account the views of the participants, since they are the ones who best understand their demands and their own needs[11], and the satisfaction of its members is an important indicator in assessing the effectiveness of the group as a therapeutic resource[12].

There is no specific instrument for assessing the work with groups, especially those developed without psychotherapeutic objective, such as support or assistance groups and health promotion groups often offered in primary health care. Thus, managers and coordinators of the interested groups assessed to guide their work still need to lead to non-specific strategies[13].

Quality of life (QOL) has been used as a health outcome measure as it meets the assumption of individualized care and considers the subjectivity of the individual cared. Thus, the objective of this study was to use the Quality of Life assessment as a means to meet the needs of participants in community health promotion groups, so that its coordinators can identify which aspects of the lives of its members can/should be better developed, with general improvement of the lives of the elderly. The aim of the research was to analyze the use of quality of life assessment as a strategy to assess the work with health promotion groups in the community.

METHOD

Ethic aspects

This study was approved by the Research Ethics Committee of the *Hospital das Clínicas*, *Universidade Federal de Goiás* and developed according to the principles of Resolution CNS 466/2012[14]. After being informed about the objectives of this study, the participants expressed their acceptance by signing the Consent form.

Design, study setting and period

A cross-sectional, descriptive and analytical study, conducted between 2012-2013, in two Family Basic Health Units (FBHU) in the city of *Goiânia, Goiás*, which have health promotion groups established in the community.

Population and sample size

The study population consisted of elderly (aged equal or over 60 years) engaged in health promotion groups in the community. The convenience sample included 46 subjects who met the following criteria: to be registered in one of two investigated FBHU; to take part in, on a regular basis group meetings, for at least three months; to demonstrate to be oriented in time and space and be able to communicate verbally; without physical or mental limitations that could result in embarrassment or discomfort. We excluded the elderly who, even expressing interest in participating and scheduled the meeting for data collection, were not found in their home at the time of data collection after three attempts.

The 46 elderly participated in two health promotion groups in the community, where practical activities of undergraduate course subjects in Nursing at the *Universidade Federal de Goiás* was conducted and had already been identified with high adherence, cohesion and satisfaction rates of the participants. The group (G1) is coordinated by the Community Health Agents of the East Sanitary District FBHU and has been functioning for 14 years, with weekly meetings that take place in a sports gymnasium, which lasts about 90 minutes. The group activity usually starts with measurement of blood pressure, stretching activities and later recreational activity. After

that, participants position themselves sitting in a circle to join the health education activities, such as lectures by invited professionals, viewing educational movies, among others, everyone is given the opportunity to provide their opinion. The closure of the activities is always done with a prayer.

The other group (G2) runs in the Health District of Campinas/Downtown and although it is coordinated by participants of the community, it has the support of nurses and nursing students, professionals and Physical Education students linked to FBHU for the development of specific activities, invited by the coordination. This group has existed for six years and the meetings take place in a public square, three times a week. The activities begin with a walk in the public square, and then the participants come together for activities such as singing, dancing, prayer and socialization. When they feel the need, they invite professionals from the FBHU for physical activities and health education. On Fridays, professionals and nursing students perform measurement of blood pressure and blood glucose test on the participants.

Besides the difference in coordination (G1 is coordinated by health professionals while G2 by an elderly community leader), the two groups differ on the frequency of meetings (once a week in G1 and three times a week for G2) and the type of activities offered (socialization and recreation in the G1 and physical activity in G2).

Study Protocol

Participants were invited to participate in the study during the group's activities, when the researcher was introduced by the coordinator, explaining the objectives and inviting the elderly to participate in the research. Considering those who agreed to participate in the study, a meeting was scheduled at their home, according to their availability.

Data were collected through individual interviews, which lasted an average of 90 minutes using three instruments: a form with socio-demographic identification and characterization of the subjects and two questionnaires to QOL assessment - WHOQOL-BREF and WHOQOL-OLD. The WHOQOL-BREF consists of 26 questions, two general questions (one about the general perception of the individual about their QOL and another on general health assessment) and 24 questions addressing the physical, psychological, social relationships and environment domains[15]. The WHOQOL-OLD has 24 questions divided into six facets: sensory ability, autonomy, past, present and future activities, social participation, death and dying, intimacy[16].

Although the two QOL assessment instruments have been built to be self-applicable, considering the age and possible visual, motor and educational level of the participants, the questionnaires were completed by the interviewer in the presence of the subject and following the recommendations of the WHOQOL group regarding not giving additional explanations on the questions[15].

Data Analysis

Data were entered into an electronic spreadsheet and those related to the QOL assessment were analyzed following the instructions of the Brazilian WHOQOL Center[15].

A descriptive analysis of the characteristics of participants, calculated as means and standard deviations of the WHOQOL-BREF and WHOQOL-OLD facets scores for each of the groups was performed. For comparison between the two groups, the scores obtained in the two instruments were compared using Student t test, the differences were considered significant when $p < 0.05$.

RESULTS

Participated in the study 26 elderly of the G1 and 20 elderly in G2. Most participants were female (84.6% and 90.0%, respectively) who were less than 80 years old (76.9% and 90.0%, respectively). Almost 2/3 of the subjects (65.2%) of G1 had up to four years of education, while in G2 80.0% reported having up to four years of education. Although the majority of participants (57.7% in G1 and 75.0% in G2) does not live with a partner, more than 2/3 of the elderly live with their children and/or grandchildren (65.4% in G1 and 76.4% in G2).

Out of all participants, 78.3% are retired, but, while nine (34.6%) subjects in the G1 could not get their retirement, in G2 only one (5.0%) was in the same situation. More than half (56.5%) of the elderly has individual income of up to one minimum salary (R$ 622.00 in 2012 and R$ 678.00 in 2013) and the majority (84.9%) reported contributing financially to the family income, despite the low personal income.

The analysis of the scores of each group (Table 1) in the WHOQOL-BREF domains indicated, in absolute numbers, higher mean in G1 on "social relations" (75.32) and lowest on "Environment" (60.22). In G2, the highest mean in absolute numbers was on "Psychological" (69.25) and the lowest also in the "Environment" domain (61.56). When comparing the two groups, we identified a significant difference between the scores in the domain of "Social Relations" ($p = 0.036$), with higher mean scores for G1 elderly.

Analyzing the responses of the elderly of the two groups regarding the questions for "Social Relations", including personal relationships, social support and sexual activity, it was observed that satisfaction with sex life was the greatest influence for G1 participants, reaching a significantly mean score ($p = 0.036$) greater than G2. While 61.6% of G1 elderly consider themselves "satisfied" or "very satisfied" with their sex life, 70.0% of the participants of G2 said they were "dissatisfied" or "very dissatisfied" with this aspect.

The WHOQOL-OLD, the G1 elderly reached the highest mean score in absolute numbers in the facet "Social participation" (72.36), while G2 participants obtained this result on the facet "past, present and future activities", (69.25). In both groups, the lowest average score, also in absolute numbers, was on "death and dying" facet (56.73 and 44.06, respectively). Comparing the mean scores of the two groups, it was observed that the G1 means were significantly higher in facets "Sensory Abilities" ($p = 0.005$) and "Death and dying" ($p = 0.023$). G2 elderly had higher mean scores ($p = 0.031$) in the facet "autonomy" (Table 2).

Table 1 – Mean scores obtained by the elderly participants of G1 and G2 in the WHOQOL-BREF domains, Goiânia, Goiás, Brazil, 2013

WHOQOL-BREF Domains	Mean ± SD		*p* value
	G1	G2	
Physical	66.76 ± 11.19	63.75 ± 14.11	0.424
Psychological	67.95 ± 11.17	69.25 ± 9.60	0.679
Social Relations	75.32 ± 15.36	66.25 ± 12.23	0.036
Environment	60.22 ± 11.20	61.56 ± 11.65	0.693

Table 2 – Mean scores obtained by the elderly participants of G1 and G2 in the facets of the WHOQOL-OLD, Goiânia, Goiás, Brazil, 2013

WHOQOL-OLD Facets	Mean ± SD		*p* value
	G1	G2	
Sensory abilities	70.00 ± 18.13	55.31 ± 14.66	**0.005**
Autonomy	58.41 ± 14.89	66.88 ± 9.31	**0.031**
Past, present and future activities	69.71 ± 11.68	69.38 ± 8.34	0.914
Social participation	72.36 ± 11.20	66.25 ± 15.20	0.128
Death and dying	56.73 ± 19.52	44.06 ± 16.03	**0.023**
Intimacy	67.31 ± 20.33	59.06 ± 17.26	0.135

The questions included in the facet "sensory abilities" assessed the functioning of the senses (sight, hearing, taste, smell and touch) and how the loss of these influences daily life, the ability to participate in various activities and interact with others. The elderly of the two groups consider that the losses in the senses affect "completely" and "moderately" his/her daily life (65.4% in G1 and 65.0% in G2) assessed as "good" and "very good" (59.0% of the participants of G1 and 50.0% of G2) the sensory abilities. However, while the G1 only 26.9% of the elderly feel that their ability to participate in activities is "completely" and "moderately" affected by the loss on the senses, in G2 this percentage was 75.0%. Similarly, the interference on the senses loss of their ability to interact with other people was assessed as "moderately" and "very important" for 32.0% of the elderly in G1, while in G2 this percentage more than doubled (70.0%).

Among the questions that assessed the facet "Autonomy" in scale of 1 to 5, the G2 participants were able to reach higher mean scores ($p=0.017$) in relation to their ability to do things that they like (3.65 in G2 and 3.12 in G1) although no statistically significant difference was found ($p=0.090$), also with regard to the perception of the respect of others for their freedom (mean 3.90 and 3.38 in G2 and in G1) and about the feeling of having control over their own future (mean 4.10 in G2 versus 3.81 in G1, $p=0.189$).

In the facet "Death and dying", the fear of not being able to control his/her own death affects less ($p=0.026$) the G1 elderly QoL (mean score of 3.54) than participants in the G2 (mean score of 2.75). Similarly, but with no significant difference ($p=0.071$), G1 participants seem to be less afraid of dying (mean score 3.54) compared to G2 (mean score 2.85).

DISCUSSION

The observation of the demographic data of the participants drew attention to specificities that need to be known by the coordinators for better planning of strategies used during activities with the elderly. The predominance of elderly people with less than 80 years in both groups was expected, since the physical and even mental limitations imposed by advanced age increases the degree of dependence, the prevalence of disability and the presence of comorbidities, hindering the participation of those considered oldest old (80 and over) in activities outside home[17]. However, since the two groups intend to promote health, perhaps this reality can be reversed with the incentive for the adoption of healthier lifestyles that keep the disease under control and retard the rise of limitations, mainly physical. Thus, the elderly can enjoy the benefits of participating in various group activities, even with the advance of age.

The female hegemony, as observed in other studies with elderly[17-18] should also be considered by the group coordinators. While these professionals cannot lose sight of the option for the maintenance strategies in the elderly group for women, they need to offer alternatives that also attract men. They must think about the particularities and interests of men, so they can understand the benefits of participating in this type of group. One possibility for the awakening of interest is offering more specific leisure activities for men, as maid of games, backgammon, chess, among others, physical activity and social interaction, which can contribute significantly to improve their QOL[19].

Low education identified in the G1 participants, elderly characteristics also observed in other studies[18-20], is common in people of this age group living in developing countries and who lived his/her childhood and youth in the time that education was not a priority . In time before the massification of education, there were fewer schools and vacancies, being of difficult access for those living in rural or remote areas of central cities to the teaching units[17]. Knowing the educational level of the group participants is essential to the strategies used during the meetings to be appropriate to the understanding of all participants, enabling their active participation, especially for the elderly, whose capacity/mental activity is usually compromised. The use

of non-understandable strategies can generate feelings of isolation and of not belonging to the group. As a result, the group adherence and research cohesion may be low as the information provided will not reach its purpose and scope of the proposed objectives and the group will be impaired.

The fact that the majority of participants do not live with a partner may be an incentive for joining and remaining in the group, because there is a quest to reduce feelings of loneliness and social isolation, as well as filling the time that the lack of a partner leaves idle in their daily life. Whereas social relationships are essential to human well-being and are significantly involved in the maintenance of health[21], the group's coordinators should be concerned to offer activities that encourage social participation of the elderly in community events and leisure activities, contributing so that the participants can feel accepted and valued in the group.

Another aspect to be observed for the coordination of the groups that is related to the individual financial income of the elderly, even when they have low income, it is still accounted for the family income. They must be careful not to provide social options, leisure or health information inaccessible to the purchasing power of the elderly, so they do not feel diminished in relation to others, or deleted for lack of financial resources. Importantly, in the perception of the elderly, one of the aspects that contribute to a better QOL in aging is to have enough monthly income to meet everyday needs[18].

In the assessment of QOL in general, the differences identified between the groups on WHOQOL-BREF "social relations", with the highest mean score for the G1, may be mainly related to the objectives and type of predominant activities in the meetings of each group. The highest score of the group also regards to questions of the facet "Social participation" of the WHOQOL-OLD, although not significantly different, confirms the positive result.

In G1, as the activities offered are more linked to socialization opportunities of its participants (leisure, sports, games and sharing life experiences), the aspect of "social relations" of the elderly life is enhanced. A previous study conducted with G1 elderly[8] investigated the presence of therapeutic factors in their meetings and also highlighted the development of social skills, which are related to conversations, conflict resolution and improvement of their loneliness condition, among others[22].

The G2 had objectives mainly related to the promotion of physical activity and the development of healthier lifestyles (walking and stretching), without much investment by coordinators in the social aspects of life of its participants. Although the value of regular physical exercise is known for physical and functional performance of the elderly, which increases their self-confidence and improves their QOL[23], the social aspects involved in the aging process cannot be forgotten.

Considering the frequency of feelings of loneliness and social isolation commonly identified in the elderly portion of the population, it is recommended that the coordinators of G2 rethink their leading style. Social isolation is an objective and quantifiable reflection of the size of social network and lack of social contacts of the subject. This factor is a particular problem of aging, when economic resources diminish, there is mobility impairment, and the death of contemporaries also conspire to limit social contacts[24]. The practice of activities that gives them pleasure and keeps them active is a common and efficient way to address the limitations imposed by chronic degenerative diseases common to the elderly, helping to alleviate this feeling of loneliness[25].

In this activity practices for recovering the social relations of the elderly, collaboration/assistance of qualified professionals can be critical for the redesign of the group, including activities directed to the promotion or improvement of social skills of its participants.

Also in regard to the "social relations" domain of WHOQOL-BREF, we draw attention to the fact that the mean scores obtained by G2 elderly in the aspect of satisfaction with their sex life to be significantly ($p=0.000$) lower than in G1 participants (3.50 in G1 and 2.15 in G2 on the scale of 1 to 5). This result may indicate that the elderly with less age (majority in G2) feel more the lack of sexual activity. Nevertheless, it is necessary to consider that, despite all the psychophysiological changes that accompany aging, sexuality is still present and part of the day-to-day life of people throughout their lives[26]. In this sense, health professionals who work with elderly groups need to update their knowledge about sexuality in old age, knocking myths and misconceptions about it, in order to provide appropriate care to this specific need.

Dissatisfaction with sexual life expressed by the elderly in this study may be related to the lack of specialized information that helps them solve problems and find healthy alternatives to improve satisfaction in this aspect of their lives. It is very convenient for the professionals to assume as true the notion that sexual interest decreases over the years and, therefore, when working with elderly, especially those with older age, this aspect of their QOL can be relegated in second place or even forgotten.

Another possibility is to use the lack of expertise to avoid working the issue with the elderly, excluding the health professional a fundamental aspect of life for active and successful aging, as sexuality is configured[27]. Ideally, seeking help from experts who could work with the elderly in the management of their difficulties, both with measures to prevent sexual dysfunction as with information on alternative forms of satisfaction to those who are with this impaired function.

In the OLD instrument, G2 elderly have reached higher mean scores than G1 on "Autonomy" facet. This may be a result of the higher percentage of participants with less than 80 years (90.0%) in group 2, with better levels of education (80.0% over four years) and retired (95.0%), with individual income greater than a minimum salary (40.0%). The limitations imposed by advanced age, both physical and in the psycho-emotional aspects, the lack of information provided by a few years of education and the relative lack of financial independence are factors that can greatly affect personal autonomy[28]. So it is not surprising that participants in the G1 have obtained lower mean score in this facet.

As the loss in autonomy is a factor that contributes to the isolation of the elderly, both in relation to other family members as social relationships outside home, this is another aspect that needs to be worked for the elderly group coordinator, reinforcing the

positive aspects involved and minimizing the negative aspects. Clearly, some variables are not subject to interventions, such as increasing age. However, it is possible to promote activities that enhance mental and intellectual level, even offering courses and training workshops for the elderly to exercise and improve their skills in making handicrafts, sweets, and other products that can be trade to help improve their personal income. This may result also in improved self-esteem[4].

In the facet "Sensory ability" in which the G1 elderly reached a mean score significantly higher than the G2, the main difference between the two groups is the perception of how the sensory losses of subjects are affecting their participation in different activities and their ability to interact with others. While few G1elderly consider small effect, for most G2 participants, sensory loss interferes substantially in their ability to participate and interact in the community.

Although the decrease in hearing, visual, gustatory, olfactory and tactile acuity are considered due to the natural aging process, it is important for coordinators to obtain information, in advance, on what is the elderly level of difficulty to understand and participate in the proposed activities for the group as one. This careful planning and implementation of activities will allow the selection of the most appropriate strategies, helping participants to feel valued, so that they can enjoy the benefits of the activities. The adherence of the participants to the group can be better if there is the use of an environment free of external sound interference, where verbal communication occurs with appropriate content to the cognitive and intellectual ability in audible volume for the present, and nonverbal communication (writing, drawings and gestures) considering the frequent visual impairment in this age group[18].

Moreover, the environment provided to the elderly for the activities and group meetings need to be adapted to these losses in directions so as to not pose a risk to his/her health. This is especially true for groups like G2, in which the activities offered are mainly walk and exercise in the public square, whose floor irregularities can be a risk factor for falls[29].

Regarding the facet "Death and dying", the worst mean score obtained by the participants of G2 can be associated to the fact that this group gather more elderly under the age of 80, with purchasing power, apparently better and with more years of education. These sociodemographic characteristics contribute so that the elderly have better insight on how vulnerable they are. But even knowing that death is inevitable, participants still feel able to do something so that death is not painful, assuming the fear of the unknown and unworthy conditions that may accompany the process of dying. Not being afraid of death may reflect an unconscious defense as the devaluation of life in adverse conditions, with expectations of a better life after death[30].

As they grow older, more participants feel close to death and disability caused by diseases. In this phase of life, experiencing the loss of other contemporaries, the elderly begin to realize that death is closer. The fear of not being able to control his/her own death may be related to the possibility of being alone and incapable at the end of life, dependent on others for their most basic needs, such as eating, hygiene, dressing, moving, among others, and not by the uncertainty and fear of death[31].

The coordination of elderly groups can help in alleviating the negative feelings related to this topic, providing help for participants to minimize anxieties and fears related to the death and dying process. The collaboration of different religious practices, psychologists and other professionals with experience in the field may be required, to be worked in a profound way, but without the weight that this topic usually brings. Every effort should be used not to deny the proximity of death, but in the sense of working acceptance of aging and personal finitude as a natural process. This process is not necessarily linked to pain and suffering, but it can occur in a dignified manner, being understood more as the closing life cycle, the closure of the missions that the subjects should have fulfilled[31].

Study limitations and contributions to the practice

Although the results of this study indicate the usefulness of the instruments for QOL assessment to help coordinators in the examination and prosecution of his/her work in leading the groups, it is necessary for these characteristics to be tested in other groups and scenarios. Moreover, it is important to consider the assessment of both the participants and the coordinators on the usefulness of these instruments to identify the needs of its participants, guiding the (re)planning and conduction of the working group. While more comprehensive and conclusive investigations are conducted, the professionals who work with groups in the community, interested in making this work more effective in its objective of education and health promotion, can use the results of this study to help them in this task.

CONCLUSION

The QOL assessment of the study participants proved to be a valuable ally in planning and conducting the work with groups, making it possible to conduct intervention strategies to improve their lives in general.

Although they were considered too long and tiring for the elderly, the WHOQOL-BREF and WHOQOL-OLD instruments enabled group coordinators to better understand their participants, providing important information for the group (re)planning. A detailed analysis of the responses to each question allows coordinators to identify how the group can collaborate to improve the QOL of its participants, reinforcing aspects positively evaluated and minimizing those whose scores indicated QOL impairment.

When the group planning is based on the real needs of its participants and the meetings are conducted following basic assumptions of group dynamics, the possibilities that the group achieve success and reach their goals are greater. Their success is directly related to the timing between the expectations and demands of the participants. Working with groups is a valuable space for learning and sharing experiences and can be used with different participants and different scenarios, but requires qualification of the professionals involved and focus on the needs of the participants. In this sense, the instruments for assessing QOL proved to be useful to highlight the needs of group participants and provide orientations for the work of coordinators in conducting the group, contributing to the success of the intervention.

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