



Quality of life of the elderly and participation in group educational activities*

Qualidade de vida de idosos e participação em atividades educativas grupais

Calidad de vida de ancianos y participación en actividades educativas grupales

Darlene Mara dos Santos Tavares¹, Flavia Aparecida Dias², Denize Bouttelet Munari³

ABSTRACT

Objective: To compare quality of life scores among elderly who participated in and those who did not participate in group educational activities. **Methods:** A cross-sectional household survey conducted with 1,255 elderly. We used descriptive analysis and the Student *t-test* ($p < 0.05$). **Results:** The majority of elderly, in both groups, were female, aged between 60 – 70 years; there was a prevalence of individuals who were married or living with a partner, residing with children, and who had a monthly income at the minimum wage. The participants predominantly presented with 1 – 4 years of study, and non-participants with 4 – 8 years. The elderly who participated in group educational activities presented lower scores in the social relationships domain, and in the facets of sensory functioning, autonomy, past, present and future activities, and social participation, as compared to those who did not participate. **Conclusion:** This study highlights the necessity for reflection about group educational activities developed in the health services, as a factor that contributes to the improvement of the conditions of health and quality of life for the elderly. **Keywords:** Aged; Quality of life; Health education; Geriatric nursing

RESUMO

Objetivo: Comparar os escores de qualidade de vida entre os idosos participativos e não participativos de atividades educativas grupais. **Métodos:** Estudo tipo inquérito domiciliar transversal realizado com 1.255 idosos. Foram usados a análise descritiva e teste *t-Student* ($p < 0,05$). **Resultados:** A maioria, em ambos os grupos, era do gênero feminino, na faixa etária de 60-70 anos; Prevaleram também os casados ou os que moravam com companheiro, residiam com filhos e tinham renda mensal de um salário-mínimo. Os participativos apresentaram predominantemente 1-4 anos de estudo e os não participativos, 4-8. Os idosos que participavam de atividades educativas grupais apresentaram menor escore no domínio relações sociais e nas facetas funcionamento dos sentidos, autonomia, atividades passadas, presentes e futuras e participação social, comparados aos não participativos. **Conclusão:** Evidencia-se a necessidade de reflexão sobre as atividades educativas grupais desenvolvidas nos serviços de saúde, como fator que contribui para a melhoria das condições de saúde e qualidade de vida dos idosos. **Descritores:** Idoso; Qualidade de vida; Educação em saúde; Enfermagem geriátrica

RESUMEN

Objetivo: Comparar los scores de calidad de vida entre los ancianos participativos y no participativos en actividades educativas grupales. **Métodos:** Estudio tipo encuesta domiciliar transversal realizado con 1.255 ancianos. Fueron utilizados el análisis descriptivo y el test *t-Student* ($p < 0,05$). **Resultados:** A mayoría, en ambos grupos, era del género femenino, en el grupo etáreo de 60-70 años; Prevalcieron también los casados o los que Vivían con su compañero, residían con hijos y tenían como ingreso mensual un salario mínimo. Los participativos presentaron predominantemente 1-4 años de estudio y los no participativos, 4-8. Los ancianos que participaban en actividades educativas grupales presentaron menor score en el dominio relaciones sociales y en las facetas funcionamiento de los sentidos, autonomía, actividades pasadas, presentes y futuras y participación social, comparados a los no participativos. **Conclusión:** Se evidencia la necesidad de reflexión sobre las actividades educativas grupales desarrolladas en los servicios de salud, como factor que contribuye para la mejoría de las condiciones de salud y calidad de vida de los ancianos. **Descriptor:** Anciano; Calidad de vida; Educación en salud; Enfermería geriátrica

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¹ Doctor of Nursing. Associate Professor of the Department of Nursing in Education and Community Health, of the Undergraduate Course in Nursing, "Universidade Federal do Triângulo Mineiro" – UFTM – Uberaba (MG), Brazil.

² Master of Health Care. Substitute Professor of the Department of Nursing in Education and Community Health, of the Undergraduate Course in Nursing, "Universidade Federal do Triângulo Mineiro" – UFTM – Uberaba (MG), Brazil.

³ Doctor of Nursing. Full Professor of the School of Nursing, Federal University of Goiás – UFG – Goiânia (GO), Brazil.

INTRODUCTION

Working in groups is an alternative in health care, in which knowledge is appreciated with creative intervention in the health-disease process of individuals. Thus, health professionals must be capable of identifying problems suitable for this type of approach⁽¹⁾.

Groups provide discussion of themes of collective interest, and could intervene in a positive manner in the day-to-day life of individuals through participative learning⁽²⁾. Among the elderly these activities may contribute to the appreciation of life, self-care, personal growth and to actively seeking their health⁽³⁾.

In this context, active aging is pointed out as being a challenge to 21st Century mankind. The WHO (World Health Organization) goal recommends participation, health and safety as factors that must be observed so that the elderly participate in society, according to their needs, desires and capabilities. Thus, groups of elderly living together are in line with the promotion of active aging, with the purpose of preserving the capabilities and potential for development of the elderly⁽⁴⁾. It is pointed out that health education should be in accordance with public health policies, which must consider functionality, autonomy, participation, care and self-satisfaction^(2,5).

In Brazil, the policy directed towards elderly health care recommends that health services should meet their needs, promoting qualification of professionals, in addition to development of and participation in groups⁽⁶⁾.

In the present study the term group educational activities was adopted to designate the groups, bearing in mind the characteristics of the actions performed in health services, in which this resource is used. In general, the elderly participate in groups denominated diabetics, hypertensives or elderly.

A literature review that focused on the development of groups within the context of Collective Health, allows one to affirm that group educational activities have frequently assumed an approach focused on disease or on health problems presented by the persons who frequent these services. However, the potential of the group could be developed as an agent of change and promotion of autonomy of the subjects involved^(7,8).

The development of effective group educational activities with the elderly may contribute to enabling them to make healthier choices in their lives⁽³⁾. Therefore, this activity could be considered a strategy for improving the quality of life of the elderly, as it consists of a therapeutic action for the participants^(2,7).

In this study, the concept of quality of life was adopted, which was elaborated by a group of studious persons, supported by the WHO, namely: "it refers to the individual's perception of his/her position in life, within the context of his/her culture and in the system

of values in which he/she lives and in relation to his/her expectations, patterns and concerns"⁽⁹⁾.

Starting from the presupposition that group educational activities could provide improvement in the quality of life of the elderly, one asks whether the activities developed in the health services have made this contribution.

No consensus was found in the scientific literature as regards this question. A study on educational intervention showed evidence of absence of a relationship between educational practice and quality of life⁽¹⁰⁾. Another investigation conducted with elderly persons observed that the participants in group activities presented higher quality of life scores⁽¹¹⁾. Whereas, no studies were found that evaluated the quality of life of elderly persons by means of instruments specifically for this age group, denoting the need to extend knowledge about this theme.

Therefore the aim of this study was to compare the quality of life scores between elderly participants and non participants in group educational activities.

METHODS

This was a cross-sectional observational study of the domiciliary enquiry and comparative type. The population sample calculation was made by the members of the Research Nucleus in Collective Health of the Federal University of "Universidade Federal do Triângulo Mineiro" (UFMTM). The calculation integrated 3,034 elderly persons, considering 95% confidence, 80% test power, margin of error of 4.0% for the interval estimates and an estimated proportion of $p=0.5$ for the proportions of interest.

In this research the sample consisted of elderly persons that fulfilled the inclusion criteria: be 60 years old or older; have obtained a minimum score of 13 points in the cognitive evaluation; male or female gender, live in the urban zone in the municipality of Uberaba (MG) and agree to participate in the study. The established criteria were met by 1,255 elderly persons. Two groups were formed: elderly participants (251) and elderly non participants in group educational activities (1,004). These groups were paired, according to sex (male and female) and age-range (60 | 70, 70 | 80, 80 and over), following the date order of data collection, in the proportion of 1 to 4.

Cognitive evaluation was based on the reduced version of the Mini Mental State Exam, validated by the researchers of the SABE Project. For each correct answer one point was considered, with a maximum score of 19 points⁽¹²⁾.

For data collection the following means were used: A semi-structured instrument, containing sociodemographic variables; quality of life was measured by the World Health Organization Quality of Life – BREF (WHOQOL-BREF) and the World Health Organization Quality of Life Assessment for Older Adults (WHOQOL-OLD).

The sociodemographic variables studied were: gender, age-range, marital status, living arrangements, schooling, individual income in minimum wages; participation in group educational activities; type of group educational activities; and place of participation.

The WHOQOL-BREF, a generic instrument, was validated in Brazil⁽¹³⁾ and is composed of 26 questions. Of these, the first two are generic and the other are distributed into four domains: physical; psychological; social relationships and environment⁽¹³⁾.

The WHOQOL-OLD module specifically for the elderly, was also validated in Brazil⁽¹⁴⁾. This is made up of 24 items distributed into six facets, namely: Sensory abilities; autonomy; past, present and future activities; social participation; death and dying and intimacy⁽¹⁴⁾.

The scores range from 0 to 100, and the highest numbers represent the better quality of life. The elderly's answers about the quality of life referred to the last 2 weeks that preceded the interview.

Data were collected in the elderly persons' homes, using the proportional stratified sampling technique, considering the various suburbs as strata. The interviews were held in the period from August to December 2008. The elderly were contacted at their respective homes and informed about the research objectives, the time when they were asked to sign the Term of Free and Informed Consent.

An electronic data storage spreadsheet was constructed by means of the Excel® software program. The data collected were digitized by two persons, with double entry. Afterwards, the consistency between the two databases was verified, and when there was inconsistency, one returned to the original interview to make the necessary corrections.

The data were transported to the statistical program "Statistical Package for Social Sciences" (SPSS) version 17.0, to proceed with analysis. The WHOQOL-BREF and WHOQOL-OLD instruments were analyzed in accordance with their respective syntaxes.

The distribution of absolute frequency and percentage, and the Students-*t* test were performed, and significance was considered when $p < 0.05$.

This study was approved by the Ethics Committee on Research involving Human Beings of UFTM; Protocol No. 897.

RESULTS

It was observed that in both groups, the majority of participants were women (67.7%) who were in the age-range from 60-70 years (51.8%).

In both groups there was prevalence of married elderly persons or those who lived with a companion, of whom 53.0% participated in activities and 48.0% who did not participate.

As regards family arrangement, predominance of elderly who lived with their children, with or without spouse was observed, with the percentage of those who participated in group educational activities (40.6%) was higher than that of those who did not participate (32.6%).

Where schooling was concerned, the highest percentages found were found for 1-4 years of schooling (41.0%) for participants in group educational activities, and 4-8 years (33.4%) for non participants.

With reference to individual monthly income, the percentages were similar in the two groups. The minimum wage prevailed, the percentage being 55% among participant elderly and 55.9%, non participants.

Among the participants in group educational activities, the majority (79.7%) frequented an activity, 16.3% two and 3.6% three. The elderly predominantly participated in group educational activities related to arterial hypertension (44.5%), the elderly (31.6%) and Diabetes mellitus (18.4%). The locations of participating in activities were: Primary Health Care Unit (34,7%), Family Health Strategy (32%) and Elderly Care Unit (16%).

As regards quality of life, in both groups the majority of the elderly considered it good, being 68.6% for non participants and 62.2% for participants.

In the self-evaluation of satisfaction with health, both groups reported being satisfied, with the higher percentage among non participant elderly (66.4%) in comparison with participants (60.6%).

The data in Table 1 below, show the distribution of quality of life scores of the elderly according to the WHOQOL-BREF.

In the two groups, the highest quality of life score was for the social relationships domain. The physical domain obtained the lowest quality of life scores in both groups, (Table 1).

Table 1. Quality of life of the elderly who participated or did not participate in group educational activities, according to the WHOQOL-BREF. Uberaba, 08 to 12/2008

Domains	Participated		Did not participate		t	p-Value
	Mean	Standard Deviation	Mean	Standard Deviation		
WHOQOL-BREF						
Physical	58.82	15.52	60.49	16.18	-1.472	0.141
Psychological	67.3	11.05	66.51	12.7	0.984	0.325
Social Relationships	67.35	12.27	69.18	12.54	-2.084	0.037
Environment	61.03	13.27	62.65	12.26	-1.845	0.065

Table 2. Quality of life of the elderly who participated or did not participate in group educational activities, according to the WHOQOL-OLD. Uberaba, 08 to 12/2008

Facets	Participated		Did not participate		t	p-Value
	Mean	Standard Deviation	Mean	Standard Deviation		
WHOQOL-OLD						
Sensory abilities	77.32	20.52	81.01	19.29	-2.583	0.01
Autonomy	56.86	14.51	61.34	13.34	-4.654	<0.001
Past, pres. and future Activities	63	14.13	65.93	13.63	-3.023	0.003
Social participation	62.43	16.32	65.41	15.29	-2.723	0.007
Death and dying	75.88	25.57	75.74	24.18	0.076	0.939
Intimacy	67.06	15.31	68.54	17.19	-1.252	0.211

Comparison between the groups showed that the elderly who participated in group educational activities presented significantly lower quality of life scores in the social relationships domain compared with those who did not participate ($t=-2.084$; $p=0.037$), Table 1.

The data in Table 2 below, show the quality of life scores in accordance with the WHOQOL-OLD.

In Table 2, it is verified that the highest quality of life score in both groups was for the sensory abilities facet. In the autonomy facet, the lowest quality of life score was observed for the two groups. Comparison between the groups showed that the elderly participants in group educational activities presented a lower score in the sensory abilities facet when compared with non participants ($t=-2.583$; $p=0.01$). The elderly who participated in group educational activities presented a lower quality of life score in the autonomy faced in comparison with non participants ($t=-4.654$; $p<0.001$). As far as the past, present and future activities facet is concerned, the elderly participants in group educational activities obtained a lower quality of life score in comparison with the non participants ($t=-3.023$; $p=0.003$). In the social participation facet, the quality of life score of elderly participants in group educational activities was lower when compared with that of the non participants ($t=-2.723$; $p=0.007$).

DISCUSSION

With reference to the higher percentage of women among the elderly who participated in group educational activities, a divergent result was found in a random clinical trial, in which there was a higher percentage among those who did not participate in educational activities (63.3%), compared with those who participated (61.1%)⁽¹⁰⁾.

The predominance of elderly from 60 | 70 years of age among the participants differs from a study conducted with elderly who frequented a convivance center, in which the highest percentage presented ages from 70 | 80 years (45.2%)⁽¹⁵⁾.

The higher percentage of married elderly or those who lived with companion among those who participated in activities, differed from that obtained in the investigation in which the percentage of married elderly who

did not participate in educational activities (76.7%) was higher than that of the participants (61.1%)⁽¹⁰⁾.

As regards family arrangement, differently from the data of this investigation, a research conducted with elderly participants at a convivance center identified diversified home arrangements in which 65.9% resided with their children and 28.4% with a companion⁽¹⁵⁾.

As far as schooling is concerned, a similar result was found in an investigation in which the elderly who participated in a convivance center had completed the 1st Cycle of Primary Education (45.7%)⁽¹⁵⁾.

Considering the profile found in the study, and those that have been divulged in other researches, it is valid to point out that health professionals must know the degree of schooling, among other aspects of this population, in order to direct more effective strategies related to the context in which they are included.

With reference to individual monthly income, a different result was found in a research conducted with elderly participants in group activities in health units, in which 55.9% lived on less than two minimum wages⁽¹⁶⁾. Income may constitute a limiting factor for access to leisure and acquisition of goods necessary for improvement in health and living conditions.

As regards participation in group educational activities, a higher percentage was found in an investigation conducted with elderly registered with Family Health Units, in which 35.6% participated in groups⁽¹¹⁾. It is possible that the higher percentage of participation related to group educational activities directed towards arterial hypertension and Diabetes mellitus, is due to the almost exclusive offer of these groups in primary care, since these are foreseen as actions of the Program directed towards arterial hypertension and Diabetes mellitus (HiperDia), recommended by the Ministry of Health⁽¹⁷⁾.

On the other hand, it is fundamental to reflect about the form and content of these group educational activities, and how they have been presented not only to the elderly, but in primary care in general. The educational practices centered on these programs, although they are in conformance with the recommendations of the Ministry of Health, at times do not favor the development of activities that promote autonomy and participation in the community⁽¹⁸⁾.

Thus, one should reflect on the contribution made by educational activities towards sustaining behavioral change and healthy habits in the day-to-day lives of participants⁽⁷⁾ with focus on that which is desirable in the control and prevention of diseases, detached from the latent needs of the group⁽⁸⁾.

From this perspective, it is suggested that researches should be conducted, seeking to identify whether the group educational activities meet the real needs and expectations of the elderly. These data may contribute to the planning and development of these actions.

The locations of participation in the activities reinforce the predominance of actions directed towards the elderly person with arterial hypertension and Diabetes mellitus, since the HiperDia activities are implemented in these health units.

As far as self-evaluation of quality of life is concerned, a similar result was obtained in another study, however, with a lower percentage (46%)⁽¹⁹⁾.

With regard to satisfaction with health, in the group activities, nurses could identify the factors that interfere negatively in the self-evaluation of health in the elderly, and implement actions with a view to its improvement.

The highest quality of life score in social relationships was similar to that found in a research conducted with elderly Brazilians⁽²⁰⁾.

The lowest score in the physical domain differs from that found in an inquiry conducted with elderly persons in the interior of the State of Minas Gerais, in which the lowest score was found in the environment domain⁽²⁰⁾. To improve the physical domain that impacts negatively on the quality of life, the nurse could contribute to the implementation of the nursing process in elderly care, by intervening in the group educational activities, nursing consultations and home visits.

The lowest score obtained in the social relationships domain by the participating elderly differed from the result found in an inquiry conducted in the Family Health Units, in which they presented the highest score (63.9) in comparison with non participants (57.4) ($p=0.007$)⁽¹¹⁾. The data of this study recommend reflection about the quality of their personal relationships, considering that the majority had a companion, and a higher percentage lived with their children, with or without a spouse. It is pointed out that the family, which is associated with strengthening relationships and represented a source of social support, frequently has difficulty in accepting and understanding aging, making the family relationship more difficult⁽²¹⁾.

In this context, the development of group educational activities should be directed towards extending social convivance, establishing ties among its members, interfacing with family members. However, it is necessary to investigate how group educational activities have been carried out, and how it has benefitted the persons involved, considering that the elderly in this study predominantly participated in arterial hypertension groups.

The highest score in the sensory abilities facet differed from that found in the elderly with the highest score in the social participation facet (72)⁽²²⁾. A similar result with regard to the lowest score in the facet autonomy was obtained among elderly participants in senior citizen groups (66.3)⁽²²⁾. This shows that in the present inquiry, the elderly of both groups found themselves restricted with regard to making their own decisions.

The nurse could contribute to improving these aspects, by identifying the factors that are associated with less autonomy, and developing actions in conjunction with elderly persons and their family members, seeking to encourage the expression of desires and the capacity to make decisions at this stage of life.

As regards the facet of sensory abilities, the impact of sensory impairment on the quality of life of the elderly was evaluated⁽¹⁴⁾. It is pointed out that the sensory organs allow the relationship of subjects with the medium in which they live, whether it is the family, work or others. Through the senses, the body perceives various situations that surround it, contribution to its integration with the environment⁽²³⁾.

The greater impact on autonomy among the elderly participants showed limitation of their liberty to make decisions. A study conducted among the elderly observed that their main worries were: They showed that they had not lost their identity by becoming elderly; to be recognized as citizens; to be healthy, to have support, convivance and family care, as well as financial independence⁽²⁴⁾.

However, the autonomy of the elderly may be guaranteed in various ways, such as giving them the opportunity to decide the choice of clothing they wish to wear; food preferences, places they would like to go to on outings, among others. It is important to recognize the capacities and potentialities present, encourage them to live and enjoy their rights as citizens, maintaining their physical and existential space⁽²²⁾.

As regards the facet of past, present and future activities, it is pointed out that seeking to achieve goals at this stage of life has been described as the phenomenon that contributes to the best quality of life and healthy aging. The elderly have the most varied aspirations, and some have already been conquered and brought a feeling of self-realization, and others are still to come⁽²⁵⁾. The lack of expectation with regard to future life may lead to living day after day with sadness and melancholy. From this perspective, the nurse should make the tie between the elderly and family members closer, with a view to greater participation in the day-to-day life of these subject, so that together, they may reconstruct new feelings and aspirations.

The lowest quality of life score of elderly participants obtained in the social participation faced shows the need to reflect on the aspects that are being worked on in the groups. One questions the approach to themes and their agreement with the needs felt by the elderly, or whether the focus has been disease, since the majority of the

elderly who participated in group educational activities directed towards arterial hypertension.

It is pointed out that social interaction collaborates with the exercise of citizenship and so that the elderly feel appreciated and included in the medium in which they live. In addition they begin to have a feeling of belonging to a group to which they can make a significant contributing, using their experience and knowledge⁽²⁶⁾.

Nurses could promote group educational activities in their space of action, by means of intersectoral articulation. In turn, when the population identifies itself with the activity, it will have satisfied its need for interpersonal relationship, making it possible to broaden and adapt to social interaction. It is relevant for the family member to be included in these spaces, and encourage participation of the elderly, with the goal of achieving closer ties of companionship that favor the sense of belong to the family and community.

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CONCLUSION

The results obtained in this research showed that the elderly who participated in group educational activities presented lower quality of life scores in comparison with those who did not participate. A different result was expected, since educational activities have the potential of contributing to the exchange of experiences and maintenance of autonomy of the elderly.

Therefore, it imposes reflection on the group educational activities developed in the health services, a factor that contributes to improving the conditions of health and quality of life of the elderly. Further investigations should be undertaken in order to go more deeply into this theme, since the cross-sectional design of this study did not allow one to assure implicit relationships of causality among the studied variables.