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Speech therapy profile of elderly participants in social groups developed in Primary Health Care

Perfil fonoaudiológico de idosos participantes de grupos de convivência desenvolvidos na Atenção Primária à Saúde

Perfil de terapia del habla de participantes de edad avanzada em grupos sociales desarollados em Atención Primaria de Saude

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Abstract

Introduction: Aging is a complex, multidimensional phenomenon, with physical, psychological, social and economic changes. These influence the reduction of the functional capacity of the individual in this period of life, and communication disorders and alterations of the stomatognathic system can be developed, requiring speech therapy in the elderly. Professionals inserted in Primary Health Care (PHC) can and should develop actions that seek to minimize frailties with the elderly. **Objective:** To identify the sociodemographic and speech therapy profile of elderly participants in social groups. **Method:** A cross-sectional, quantitative study with elderly people aged 60 years or older, of both sexes, participants of coexistence groups, assisted by the Family Health Strategy (FHS) teams and the Extended Center for Family Health and Primary Care (NASF - AB) of the II Health District of Maceió/Alagoas. Questionnaires adapted from validated instruments on sociodemographic characteristics, general clinical and speech

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therapy aspects were applied to the elderly and analyzed descriptively. **Results:** Participants were 54 elderly, 90.7% women, widows (44.4%), with 1 to 4 years of schooling (42.6%) and retired (72.2%); hypertensive (74.1%), with osteoarticular diseases (63.0%) and physical activity practitioners (37.0%). They presented alterations in speech-language pathology aspects: 64.8% chewing; 66.7% swallowing; 55.6% voice; 98.1% speech and language; and 85.2% hearing. **Conclusion:** Speech-language alterations were recurrent in the elderly, reinforcing the need for actions based on health promotion and prevention, and comprehensive and closer care must be provided to users enrolled in their area.

Keywords: Speech, Language and Hearing Sciences; Primary Health Care; Aged; Health Education.

Resumo

Introdução: O envelhecimento é um fenômeno complexo, multidimensional, com alterações físicas, psicológicas, sociais e econômicas. Estas influenciam na redução da capacidade funcional do indivíduo neste período da vida, podendo ser desenvolvidos distúrbios da comunicação e alterações do sistema estomatognático, sendo necessária a atuação fonoaudiológica na saúde do idoso. Os profissionais inseridos na Atenção Primária à Saúde (APS) podem e devem desenvolver ações que busquem minimizar fragilidades com a pessoa idosa. **Objetivo:** Identificar o perfil sociodemográfico e fonoaudiológico de idosos participantes de grupos de convivência. **Método:** Estudo transversal, quantitativo com idosos de idade igual ou superior a 60 anos, de ambos os sexos, participantes de grupos de convivência, assistidos pelas equipes de Estratégia de Saúde da Família (ESF) e do Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF – AB) do II Distrito Sanitário de Maceió/Alagoas. Foram aplicados questionários adaptados de instrumentos validados, sobre características sociodemográficas, aspectos clínicos gerais e fonoaudiológicos aos idosos e analisadas descritivamente. **Resultados:** Participaram 54 idosos, sendo 90,7% mulheres, viúvas (44,4%), com 1 a 4 anos de escolaridade (42,6%) e aposentadas (72,2%); hipertensas (74,1%), com doenças osteoarticulares (63,0%) e praticantes de atividade física (37,0%). Apresentaram alterações nos aspectos fonoaudiológicos: 64,8% mastigação; 66,7% deglutição; 55,6% voz; 98,1% fala e linguagem; e 85,2% audição. **Conclusão:** As alterações fonoaudiológicas foram recorrentes nos idosos, reforçando a necessidade de ações pautadas na promoção e prevenção da saúde, sendo prestada uma assistência integral e mais próxima aos usuários adstritos a sua área.

Palavras-chave: Fonoaudiologia; Atenção Primária à Saúde; Idoso; Educação em Saúde.

Resumen

Introducción: El envejecimiento es un fenómeno complejo y multidimensional, con cambios físicos, psicológicos, sociales y económicos. Estos influyen en la reducción de la capacidad funcional del individuo en este período de la vida, y pueden desarrollarse trastornos de la comunicación y cambios en el sistema estomatognático, que requieren terapia del habla en la salud de los ancianos. Los profesionales en atención primaria de salud (APS) pueden y deben desarrollar acciones que busquen minimizar las debilidades con los ancianos. **Objetivo:** Identificar el perfil sociodemográfico y del habla y el lenguaje de los participantes de edad avanzada en grupos sociales. **Método:** Estudio cuantitativo transversal con personas mayores de 60 años o más, de ambos sexos, que participan en grupos sociales, con la asistencia de los equipos de la Estrategia de Salud Familiar (FHS) y el Centro de Salud y Atención Familiar Extendida (NASF - AB) del II Distrito de Salud de Maceió/Alagoas. Se aplicaron cuestionarios adaptados de instrumentos validados, sobre características sociodemográficas, aspectos clínicos generales y de habla y lenguaje a los ancianos y se analizaron descriptivamente. **Resultados:** Participaron 54 personas mayores, siendo 90.7% mujeres, viudas (44.4%), con 1 a 4 años de escolaridad (42.6%) y jubilados (72.2%); hipertensos (74.1%), con enfermedades osteoarticulares (63.0%) y practicantes de actividad física (37.0%). Presentaron cambios en los aspectos del habla y el lenguaje: 64.8% de masticación; 66.7% deglutition; 55,6% de voz; 98.1% habla y habla; y 85.2% de audiencia. **Conclusión:** Los trastornos del habla y el lenguaje fueron recurrentes en los ancianos, lo que refuerza la necesidad de acciones basadas en la promoción y prevención de la salud, con una asistencia integral más cercana a los usuarios en su área.

Palabras clave: Fonoaudiología; Atención Primaria de Salud; Anciano; Educación en Salud.

Introduction

Population aging process is a complex, multidimensional, natural phenomenon, comprising physical changes, as well as psychological, social and economic alterations that influence a reduction in the individual's ability to adapt[1]. According to the World Health Organization (WHO), active aging is based on the assumption that the improvement in life quality happens safely, based on an improvement in aspects related to the health of the elderly[2].

In Brazil, population aging process occurs quickly, in unfavorable economic, social and health conditions. According to the Brazilian Institute of Geography and Statistics (IBGE) the population of people over 60 years old, in 2010 was equivalent to 6,1% of the total population of the country, in 1980 it corresponded to 6,1%, in 2010 to 10, 8% and the estimates for 2020 and 2050 point to 14,0% and 30,0%, respectively[3]. Due to this increase, the weaknesses and exposure to pathological factors require a differential look and professional qualification for an intervention in the appropriate way[4].

It is in the context of Primary Health Care (PHC) that is possible interventions that favor integral care, longitudinal to the user, their family and community. The Family Health Strategy (FHS) teams configure a model for reorganizing health care, with a role in strengthening PHC. For effective resolution, ESF teams can count with the technical-pedagogical and assistance support established by the Family Health Support Centers (FHSC-AB), an essential strategic device for the care of people. Both the FHS and the FHSC-AB search comprehensive care for the population, in addition to the use of light technologies, welcoming and qualified listening, building a bond with users, avoiding a practice focused on the curative biomedical care model[4-5].

Among the professionals who can compose the FHSC-AB, the speech therapist is highlighted and, among its performance, the one directed to the elderly is emphasized, focusing on interventions about disorders of human communication and the functions involved by food, for having been changed over the years. Alterations in mastication, swallowing, voice, speech, language and hearing are aspects that influence the participation of activities, both individual and collective. This professional together enables, with the elderly, conditions to obtain favourable communicative resources and adaptations to their needs, safely and efficiently[6].

In addition, the speech therapist and other professionals who are part of FHSC- AB and the FHS team can and should develop care based on promoting actions that search to minimize their weaknesses, and also activities that allow a dialogical-reflective relationship, resulting in awareness of the elderly about their health, in addition to the perception of their autonomy and independence related to life[7]. Providing quality of life to the elderly allows them to have positive experiences that favor longevity, enabling them to achieve satisfactory aging[8], to be socially active, thus reducing expenses with medical and pharmacological treatments[9]. Despite the natural changes that aging can present, the active elderly are those who are able to conduct their activities of daily life by their own means and autonomously[5].

According to Vecchia et al[10], quality of life is related to self-esteem, personal well-being, also involving functional, emotional capacity, social interaction, socioeconomic level, health status and lifestyle. For Horikawa and Baraldi[6], a healthy old age depends on minimizing the consequences of chronic-degenerative diseases and thus enabling dignity until the last days of life.

Devices such as spaces for social groups and health promotion actions, commonly utilized by teams in FHS, allow a significant improvement in relation to collective and individual health, with repercussions on aspects related to social, cultural, economic and, mainly, on life quality[11]. The user who participates in these activities becomes a transformer, operator of changes, and better deals with health problems[11].

The moments of health education have potential to supply the necessity that individuals express, being an exchange of knowledge between professionals and users, prioritizing preventive measures and promoting life, organizing a practice of the professionals actuation that work with the reality and needs in your health unit. Thus, professionals can dimension aspects of global development within their groups that sometimes make it impossible for the elderly to participate and interact with others[5].

The present study aimed to identify the sociodemographic and speech-language profile of elderly participants in social groups, providing support for the FHS and FHSC-AB teams to improve their activities and actions with priority to

the promotion and prevention of health problems, in order to provide comprehensive and closer assistance to users assigned to their areas.

Method

This is a cross-sectional, quantitative study with 54 elderly people (aged 60 years or more), of both genders, forming social groups in Family Health Units (FHU) in the II Health District of Maceió/Alagoas (AL), which are assisted by FHS and FHSC-AB teams. Five FHUs are part of this district, but due to the number of FHS teams, FHSC-AB operates in the territory with only four of these units. Elderly people with self-reported cognitive impairment or psychosocial suffering that prevented them from answering the questionnaires, as well as those which were not present on the day of collection were excluded. The collection period was from June to August 2019.

Initially, contact was made with the administrative management of the Health Units and the coordination of each group, with a survey of those who maintained active participation in activities and visits to the groups being scheduled. The elderly people present on the day of the group were invited to participate in the study and those who accepted were conducted to a separate room, receiving oral and written information about the objectives and methodology, utilizing an accessible language and, also, the Free and Informed Consent Term (FICT) was read.

Also during this visit, the Mini Mental State Examination (MMSE)[12] was applied with the aim of tracking cognitive processes of orientation, immediate memory, attention and calculation, evocation and language, as well as performing the screening for participation in the research. The MMSE score ranges from zero to 30 points, considering the level of education, being defined as the cutoff point: ≥ 13 points for illiterates, ≥ 18 points for less than eight years of education and ≥ 26 points for individuals with more than eight years of study.

After this, a structured interview was conducted, based on questionnaires referring to sociodemographic characteristics (adapted from E-SUS Form[13]) [Figure 1], to general clinical aspects (adapted from the Comprehensive Geriatric Assessment of the Brazilian Society of Geriatrics and Gerontology (AGA- SBGG)[14]) [Figure 2] and speech therapy (adapted from Lima et al[15] and Behlau et al[16]) [Figure 3], so that it became based on the participants' self-report. Its application was performed in a reserved place, the questions being asked orally and marked in a specific form, avoiding constraints to the illiterate or functional illiterate.

The data were collected in a standardized form and the same were stored in an electronic data spreadsheet (Microsoft Excel® 2013. Redmond, WA, USA). In which each line corresponded to a research subject/form and each column to the information obtained in the collection.

The information was analyzed utilizing descriptive statistics with absolute frequency and percentages, considering the sociodemographic variables: age, sex, education, marital status, occupation and family income; the variables of comorbidities: Arterial Hypertension, Diabetes Mellitus, cardiovascular, osteoarticular, pulmonary diseases, gastroesophageal reflux and medication use; and speech therapy variables: mastication, swallowing, voice, speech, language, hearing and balance.

The study was submitted to the Research Ethics Committee of the Alagoas State University of Health Sciences (UNCISAL) in the CEPs/CONEP System and approved under protocol number CAAE 10711019.7.0000.5011.

Questionnaire Number			
Age			I do not wish to answer ( )
Date of birth	_____/_____/_____		I do not wish to answer ( )
Sex:	Female ( ) Male ( )		I do not wish to answer ( )
Participates in the group (s):			
Assisted by the Family Health team:	Yes ( ) No ( )		I do not wish to answer ( )
If Yes, who is the ACS?			
FHC	(1) Durval Cortez (2) Hélvio Auto (3) Caic – Virgem dos Pobres (4) Tarcísio Palmeira		
Education Illiterate ( ) 1-4 years ( ) 5-8 years ( ) > 8 years ( ) I do not wish to answer ( )	**Marital status** Married or consensual union ( ) Judicial / separated ( ) Divorced ( ) Widowed ( ) Not married ( ) Separate ( ) I do not wish to answer ( )	**Occupation** Retired with another occupation ( ) Retired without other occupation () Domestic jobs ( ) Work outside the home ( ) I do not wish to answer ( )	**Income** Retirement ( ) Pension ( ) Children's allowance ( ) Rent ( ) Job ( ) Others _____ I do not wish to answer ( )
Place of residence Single storey house ( ) Duplex House ( ) Apartment ( ) LTIE* ( ) Others ( ) I do not wish to answer ( )	**Residence** Alone ( ) Children ( ) Other family members ( ) Housekeeper ( ) Caregivers ( ) Others ( ) I do not wish to answer ( )	**Religion** Catholic ( ) Evangelical ( ) Spiritist ( ) Buddhist ( ) Other _____ I do not wish to answer ( )	**Social Activities** Yes ( ) No ( ) What activities _____ I do not wish to answer ( )

Adaptation created from the E-SUS Form[13]
* LTIE: Long Term Institution for the Elderly

Figure 1. Sociodemographic questionnaire

Inventory of previous diseases

Did you have or do you have a disease?	Yes ( ) No ( ) I do not wish to answer ( )
What disease?	
Do you use medication?	Yes ( ) No ( ) I do not wish to answer ( )
What medications?	

Clinical Dimension

<table>
<tr><td colspan="2">Normal vision ( )
Visual deficit ( )
Use visual correction ( )
I do not wish to answer ( )</td><td colspan="2">Hypertensive: Yes ( ) No ( ) I do not wish to answer ( )
Gastroesophageal reflux: Yes ( ) No ( ) I do not wish to answer ( )
Diabetic: Yes ( ) No ( ) I do not wish to answer ( )
Pulmonary disease: Yes ( ) No ( ) I do not wish to answer ( )</td></tr>
<tr><td colspan="2">Cardiovascular diseases
Yes ( ) No ( ) I do not wish to answer ( )

Osteoarticular diseases
Yes ( ) No ( ) I do not wish to answer ( )</td><td colspan="2">Use of orthoses:_____
I do not wish to answer ( )

Use of prostheses: _____
I do not wish to answer ( )</td></tr>
<tr><td>Polypharmacy
Yes ( ) No ( )
I do not wish to answer ( )</td><td>Smoking ( )

No smoking ( )

Ex-smoking ( )

If so, how long ago? _____
I do not wish to answer ( )</td><td>Safe use of alcohol ( )

Harmful use of alcohol ( )
Alcohol addiction ( )
No alcohol use ( )
If so, how long ago?
_____
I do not wish to answer ( )</td><td>Do not do physical activity ( )
Walks( )
Muscle workout ()
Water aerobics ()
Others _____
How many times / week?
_____
I do not wish to answer ()</td></tr>
</table>

Adaptation created from the Comprehensive Geriatric Assessment of the Brazilian Society of Geriatrics and Gerontology (AGA-SBGG)[14]

Figure 2. Questionnaire referent to the clinical aspects

Data related to Speech and Language	
Do you have any difficulty of speaking a word	No ( ) Sometimes ( ) Yes ( ) I do not wish to answer ( )
Perceives your slower speech	No ( ) Sometimes ( ) Yes I do not wish to answer ( )
Perceives your speech faster	No ( ) Sometimes ( ) Yes ( ) I do not wish to answer ( )
Difficulty of understanding something	No ( ) Yes ( ) I do not wish to answer ( )
Difficulty of expressing something	No ( ) Yes ( ) I do not wish to answer ( )
Has memory difficulty	No ( ) Yes ( ) I do not wish to answer ( )
If Yes, what type?	Short term ( ) Medium term ( ) Long term ( )
Difficulty of reading	No ( ) Yes ( ) I do not wish to answer ( )
Difficulty of writing	No ( ) Yes ( ) I do not wish to answer ( )
Data related to Hearing and Balance	
Has hearing loss	No ( ) Yes ( ) I do not wish to answer ( )
If Yes, which ear	Right ( ) Left ( ) Both ( )
Presence of dizziness	No ( ) Yes ( ) I do not wish to answer ( )
Presence of tinnitus	No ( ) Yes ( ) I do not wish to answer ( )
Use of hearing aids	No ( ) Yes ( ) I do not wish to answer ( )
Time of use of hearing aids	
Asks to repeat several times what the other says	No ( ) Yes ( ) I do not wish to answer ( )
Does it increase the volume of television, radio, etc.?	No ( ) Yes ( ) I do not wish to answer ( )
Do others complain that you speak loudly?	No ( ) Yes ( ) I do not wish to answer ( )
Feel more difficult of listen	Right Ear ( ) Left Ear ( )

Adaptation created from Lima et al[15] and Behlau et al[16]

Figure 3. Questionnaire on phonoaudiological aspects

Results

There were performed 56 interviews; however two participants were excluded from the research for not obtaining the minimum score in the MMSE. The age of the participants ranged from 60 to 88 years, with an average of 70 years (standard deviation = 7 years). There was a predominance of females (90,7%), educational level from one to four years and retirees (72,2%), with retirement being the only family income (66,7%), as described in Table 1.

Table 1. Sociodemographic characteristics relating to the elderly participants in social groups developed in PHC, Maceió/AL; 2019 (N=54)

Variables	N	%
Sex		
Female	49	90,7
Male	5	9,3
Education		
Illiterate	11	20,4
1 to 4 years of study	23	42,6
5 to 8 years of study	10	18,5
More than 8 years of study	10	18,5
Marital status		
Married	15	27,8
Single	8	14,8
Widower	24	44,4
Divorced	7	13
Occupation		
Retired without occupation	39	72,2
Retired with occupation	3	5,6
Domestic jobs	10	18,5
Others	2	3,7
Income		
Retirement	36	66,7
Pension	10	18,5
Others	6	11,1
none	2	3,7
TOTAL	54	100

Table 2 contains data regarding the clinical dimension. It is noteworthy that only 37% do physical activities with a predominance of walking (27,7%).

Regarding speech-language characteristics, Table 3 exhibits the main changes found in the functions of mastication, swallowing, voice, speech and language, hearing and balance; and also the percentage of normal and altered speech therapy aspects. In addition, 83,3% reported eating all food consistencies.

Table 2. Clinical findings concerning elderly participants in social groups developed in PHC, Maceió/AL; 2019 (N = 54)

Variables	N	%
Use of medication		
Yes	47	87
No	7	13
Visual deficit		
Yes	44	81,5
No	10	18,5
Arterial hypertension		
Yes	40	74,1
No	13	24,1
Uninformed	1	1,9
Osteoarticular diseases		
Yes	34	63
No	20	37
Diabetes Mellitus		
Yes	19	35,2
No	35	64,8
Gastroesophageal reflux		
Yes	8	14,8
No	46	85,2
Pulmonary diseades		
Yes	6	11,1
No	48	88,9
Cardiovascular diseases		
Yes	11	20,4
No	42	77,8
Uninformed	1	1,9
TOTAL	54	100

Table 3. Alteration in speech audio characteristics regarding elderly participants in social groups developed in PHC, Maceió/AL; 2019 (N = 54)

Variables	N	%	Phonoaudiological Aspects	
			Normal (N | %)	Alteration (N | %)
Mastication				
Difficulties	12	63,2	35 | 64,8	19 | 35,2
Pain	10	52,6		
Tiredness	7	36,8		
Swallowing				
Choking	26	72,2		
Liquid help during meals	21	58,3	18 | 33,3	36 | 66,7
Dry mouth feeling	26	72,2		
Cough	15	41,7		
Voice				
Clearing	23	76,7	24 | 44,4	30 | 55,6
Hoarseness	18	60		
Tiredness in the use of voice	14	46,7		
Speech and Language				
Expression	20	37,7		
Understanding	33	62,3		
Slow speech	15	28,3	1 | 1,9	53 | 98,1
Difficulty of speaking a word	22	41,5		
Reading	32	60,4		
Writing	32	60,4		
Short-term memory	36	67,9		
Hearing and Balance				
Bilateral hearing loss	11	23,9		
Dizziness	31	67,4	8 | 14,8	46 | 85,2
Buzz	26	56,5		
Increase volume of television, radio	26	56,5		
Complaints of others for speaking loud	20	43,5		

Discussion

Regarding the sociodemographic profile, the predominance of females, mostly widows, retired, with low levels of education and also income, is similar to other studies[5,17], suggesting that women are more concerned with health and they search health services more frequently, thus leading them to participate in social groups[5], looking for company and other spaces outside their home environment. Furthermore, data indicate that widowed elderly people are more resistant to participating in activities after their retirement[17]. With regard to married elderly, the support and the partner's support enables more security and encouragement to health care[5].

The low level of education is directly related to income and can influence the performance of activities developed individually or collectively, the capacity for functional independence, in addition to limiting access to their own rights and a professional career[18], leading them to support themselves only with the amount attributed to retirement and even being the home provider. An occupation linked to retirement could provide an improvement in the quality of life, making it more active and independent[1].

This study revealed what was already mentioned in others: over the years, there is an increase in comorbidities, especially chronic noncommunicable diseases[17] and, consequently, high use of medications[18]. One study demonstrated that 94,8% of the elderly reported having Arterial Hypertension and 44,8% Diabetes, with these injuries being attributed to restricted access to information and unhealthy habits[17]. Herein, strategies and incentives for promotion and prevention actions are necessary to change this reality, in which the FHS and

FHSC-AB teams can offer differential monitoring with users and greater assistance to this audience.

Other comorbidities present in the elderly population refer to visual deficits and cardiovascular and pulmonary diseases. With regard to visual deficits, these can generate falling events, leading to fractures and thus reducing sensory function[19]. Regarding cardiovascular diseases, although the data presented in this study are insignificant, they can be associated with difficulties and/or pain when swallowing and cause a decrease in pharyngeal transit[20]. In turn, in relation to lung diseases, these can be related to an incoordination of swallowing and causing pneumonia[21].

Osteoarticular diseases were also frequent in this study, showing that they are prevalent in the elderly, especially women, and they can cause an increase in falls and fractures, resulting in dependence on activities of daily living and decreased physical performance[22]. The incentive to practice physical activity must be paramount, the Brazilian Longitudinal Study of Aging (BLSA-Brazil) conducted in some municipalities demonstrated that the lower the level of education and the increase in age, the lower the levels of physical activity[23]. The elderly person is more sedentary, which can result in reduced mobility[22]. Social groups are ideal for the elderly to have a better and healthier lifestyle, preventing and controlling injuries[17], having as main practice the walks to be conducted in the community territory.

Communication is essential to relate, however, with advanced age, this function can be negatively affected, influencing quality of life, independence and even a restriction or loss of social participation[24]. The most frequent speech-language disorders in this study were related to the stomatognathic system, slowness in speech processes, phonation, hearing and body balance difficulties that corroborate with others researches[24,25], showing the importance of data related to aging in the speech therapy area of care to the elderly health[25].

Some alterations found in masticatory function corroborate with another study that evidences difficulties in mastication, presence of cough and/or choking, tooth loss and use of prosthesis[26]. The mastication process in the elderly requires special care, since myofunctional disorganization can lead to complications in mobility, tonicity, in the functionality of the organs and also affect swallowing[26]. In addition, gastroesophageal reflux, often found in the elderly, can be the cause of difficulties in swallowing, consequently leading to the sensation of food standing in the throat and throat clearing[20].

A study performed in São Paulo demonstrated that difficulties such as choking, the help of liquid to swallow and the feeling of dry mouth are aspects that are frequently reported by the elderly and that may be related to the decrease in functional capacity, being a risk for the appearance of presbyphagia and dysphagia[20]. Interventions to promote the health of orofacial functions are necessary and can be performed in collective spaces searching to minimize the physiological and functional decline of the stomatognathic system caused by aging[27].

The vocal quality also changes in the course of the aging process, transforming the structures and their functionalities and consequently negatively impacting on interaction, socialization, expressiveness and quality of life. In addition to presbyphonia (natural aging of the voice), vocal abuses, such as shouting and speaking with effort, are also influential in vocal health[18].

Alterations in communicative functions are common in old age, causing difficulties in expressing and understanding speech, short and long term memory, reading and writing and which can impede social integration, showing social isolation, stress and restriction in autonomy[18,28]. A study demonstrated that the low level of education is also a factor for the increase in reading and writing difficulties, due to their social relationships and the opportunities to which individuals were exposed throughout life[18]. These difficulties interfere with linguistic and cognitive aspects, reflecting on their activities performance.

Regarding the auditory aspects, a study in Florianópolis identified that the decrease in auditory acuity generates impacts on social life and communication[29]. The complaints reported in the present study are similar to a research that shows that almost half of the individuals refer to "listening to television and radio very loudly", presenting losses in the absorption of information by the media and even losses in interpersonal contacts[18].

Given these findings, it is possible to state that it is necessary to a speech therapy approach with the elderly in the FHS; the participation of speech therapy in this level of health care enables the expansion of care to this population. Changes in aspects involving the stomatognathic system and communication interfere with verbal and non-

verbal communicative performance and personal relationships[30]. Thus, it is necessary to minimize any difficulties for the insertion of the elderly in daily (daily life), community activities and in health education/social groups.

Regarding the groups, their periodicity must also be analyzed, since the link established between the FHS teams with the users can be "broken" with longer intervals between meetings, which may be one of the reasons that caused the closure of one of them in one of the Health Units surveyed (in the others, two groups occur fortnightly and in another monthly), as it may also be one of the causes of low user compliance. Remembering that the performance model foreseen in the policies by the FHS teams, and also by the FHSC-AB teams, implies longitudinal care, responding to the needs of individuals,[17] and maintaining with this practice the strength of the bond with the user and the community, in a way that their quality of life is strengthened.

Conclusion

In the sociodemographic and clinical profile of the elderly participants in social groups, there was a predominance of women, with an average age of 70 years, widows, with education between one and four years and retired. Regarding health data, hypertensive elderly women, with osteoarticular diseases and performing some physical activity, predominated.

Regarding speech therapy conditions, the most frequent were: difficulty, pain and tiredness when masticating some food; choking, help with liquid during meals, feeling dry and coughing; throat clearing, hoarseness and tiredness in the use of the voice; difficulties in understanding and expression, reading and writing, speaking a word, difficulties in short-term memory and slowed speech; bilateral hearing loss, dizziness, tinnitus, need to increase the volume of television, radio and the fact that others complain about them speaking loudly.

Speech-language disorders were recurrent in the elderly, reinforcing the need for actions based on health promotion and prevention, with comprehensive and closer assistance being provided to users in their area. In addition, it also allows changes in the communicative aspects of the elderly, which reflect on their activities of daily living and social life. Thus, the study can contribute so that professionals from the FSH and FHSC-AB teams can appreciate and promote the autonomy and participation of the elderly in the territory, providing active aging.

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