

A DESCRIPTIVE STUDY ON ASSESSING THE “QUALITY OF LIFE” OF ELDERLY POPULATION RESIDING IN THE VILLAGES NEAR BARU SAHIB (H.P.)

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ABSTRACT

Quality of life is a concept in environmental, social and psychological sciences, it’s a multidimensional concept elderly group is more vulnerable to get the disease so resulting in decreased quality of life. so the present study was conducted to assess the “Quality of Life” in rural areas residing villages near Baru Sahib. We emphasized on the elderly age group (above 60) the objectives for the study were, first to assess the impact of various factors on QOL. In present study mainly four domains were focused as physical, Psychological, social and Environmental. To conduct the study 52 subjects were selected by purposive sampling technique. We used standardized WHOQOL-BREF tool for the assessment. Descriptive and inferential statistics were used to analyze the findings. Among all the subjects 68% were males whereas 32% were females. Regarding education status maximum of the subjects were illiterate. Regarding occupation 84% were depend on the agriculture 4% on pension 12% on children, 93% of the Respondents belonged to Hindu religion and 7% belonged to Sikh religion. According to habitat they were rural. The Findings revealed the mean for physical domain (11.84), psychological domain(12.74) social domain (14.48) and for environmental domain (11.48) and findings of the standard deviation for physical domain is (3.07), psychological (5.47), social (3.68) and environmental(3.35) Therefore the study findings revealed social domain was more significant and effect of Habitat, occupation and age were seen more on the elder’s quality of life.

Keywords: *Quality of Life, Elderly Population.*

INTRODUCTION

“Nature is wise: instead of doing patch repairs of normal body wear and tear, she builds another individual from the old material; and yes, father and mother live in their children forever”

QoL is a key concept in environmental, social, medical and psychological sciences, as well as in public policy and in the minds of the population at large; nevertheless, there is no consensus regarding the definition of QoL (Fernández-Ballesteros, in press^[1])

Quality of life is a multidimensional concept. That encompasses the physical, psychological, social, spiritual, sexual, occupational, well-being of a person. Three major life domains are being belongings, & becoming. Being domains includes the basic aspect of “who one is” Belonging includes the persons fitness with his/her environments^[3] Becoming refers to the purposeful activities carried out to achieve personal goals, hopes & wishes. Caring for older patients poses special challenges: While most remain quite healthy and independent, many others are at great risk of falling, developing dementia, and experiencing depression and anxiety.^[2]

Most people are taking more responsibility over their personal health and well-being. Research has shown that keeping the mind and body active gives people a quality of life, even as they get older. The government has changed the age of retirement so many seniors continue working, some out of necessity and others out of a choice to continue doing what they love. With vast amounts of information available via the Internet, people feel more empowered to make informed decisions about their life choices and refuse to settle for what used to be the “expected” progression of aging^[3]

These factors include personal and environmental contextual variables. For example, a knee injury may limit joint movement. For a young man whose aim in life is to become a professional football player, this disability seriously affects his QOL. But for another person whose profession involves mainly reading and writing, the same disability affects the QOL to a lesser extent. Hence, a QOL questionnaire aims to assess the extent to which significant aspects of a person's life have been affected, rather than what symptoms and disabilities are present. This concept of measuring QOL also makes it easier to construct a generic instrument that can be applied to individuals suffering from illnesses of diverse nature and severity, than to devise

an instrument a patient's life beyond symptoms and signs.^[4]

The differential effects that intervention techniques may have on various quality of life domains and to gain information about the likelihood of acceptance that an intervention can achieve when applied in clinical practice with old people. Interventions that improve physical status, quality of life indicators may be predictors of treatment success. It is not possible to compare the relative productivity of the different intervention strategy in order to draw public policy implications, it is important to be able to specify which interventions produce the greatest return per dollar of investment^[5]

The interventions represent a wide range of resource intensity, from team oriented clinical interventions with several professional scarring for individual patient, to group health behavior interventions with a ratio of 1 interventionist to 10 or 15 quality of life assessment will help us to determine whether high intensity interventions are worth their additional cost, or if low technology methods are better values. ^[6]

NEED OF THE STUDY

The ageing of the population is associated with an increasing demand for services. Elderly are more challenged population because they may not have the physical stamina, could not care themselves and are at risk of illness. Life assessment based on a person's own opinion of his/her physical, emotional, social well-being so Quality of life assessment becomes major criteria for evaluating health and medical intervention, it is the necessity to assess specific physical, psychological and social problems by appropriate subjective and objective assessment of all the domains of quality of life.

LITERATURE REVIEW

Quality is an innovative, quantitative and qualitative research project that aims to examine how, in an era of major change, European citizens living in different national welfare state regimes evaluates the quality of their lives. "LIFE" is an error making and error correcting process, and Nature is making man's paper will grade him for wisdom as measured both by survival and by the "quality of life" of those who survive .. John Stewart Mill noted that individual opinion about well-being was 'the best means of knowledge immeasurably surpassing those that can be possessed by any one else.'^[1] Thus, quality of life is highly

individualistic and might even be an ‘idiosyncratic mystery’ due to the high levels of variability between individuals, making it unsuitable for decision making. The multidimensional approach to QOL is to produce a synthesis of question. 9 aspects of quality of life for which peoples are exposed – their health, their level of education, working condition, involvement in public life, economic security and physical security^[3]

This study was designed as a systematic review and meta-analysis, following the "Preferred Reporting Results of Systematic Reviews and Meta-Analyses" (PRISMA) Twenty five studies were included. Mean overall HRQoL was 54.92 [95%CI 51.50–58.33], lower than the value found by studies done in other countries, especially in those economically developed. The sensitivity analysis indicated stability and reliability of results. Pooled scores of each HRQoL domain/sub-scale of the questionnaire ranged from 49.77 (physical role functioning) to 63.02 (social role functioning). HRQoL among healthy elder Iranian individuals is generally low. Health policy-makers should put HRQoL among the elderly as a priority of their agenda, implementing ad hoc programs and providing social, economic and psychological support, as well as increasing the participation of old people in the community life and use their experiences.

Elderly people’s perceptions about quality of life

Most of the quality of life measures are not developed in elderly populations, although they are capable of thinking and talking about their quality of life ^[7]. In a survey of individuals aged 65 years or more, the respondents were familiar with the term quality of life and talked about it in both positive and negative terms. They evaluated their quality of life positively on the basis of comparison with others, social contacts especially with family and children, health, material circumstances and activities. In making negative evaluations, Different kinds of losses such as ill health and functional limitations were seen as making quality of life worse. Using a content analytical approach to responses to open-ended questions, they identified constituent factors of quality of life as social relationships, social roles and activities, Gabriel and Bowling attempted to develop a conceptual framework about the quality of life using older people’s views.²⁵ Factors enhancing the quality of life were having good social relationships with children, family, friends and neighbours; neighbourhood social capital represented by good relationships with neighbours, nice and enjoyable neighbourhood, comfortable houses and good public services such as free transport facilities; psychological factors such as optimism and positive attitude, contentment, looking forward to things, acceptance and other coping strategies; being actively engaged in social activities^[8]

Psychological acceptance amongst the elderly

The researchers describe this effect as “adjustment to ageing”, an important aspect of quality of life. This adaptation to change may be related to acceptance, the willingness to have the unpleasant emotions and thoughts that come in response to negative changes. Perhaps increased knowledge enabled them to adapt more readily and accept changes. The scales that measure QOL usually have a predefined set of domains and work on certain assumptions, importantly that an individual's or group's QOL is primarily mediated by the presence or absence of physical disability and limitation. This aspect is also reflected in the utility measures of QOL, such as quality-adjusted life-years, of life is ability-adjusted life-years, and health-adjusted life-years^[7]

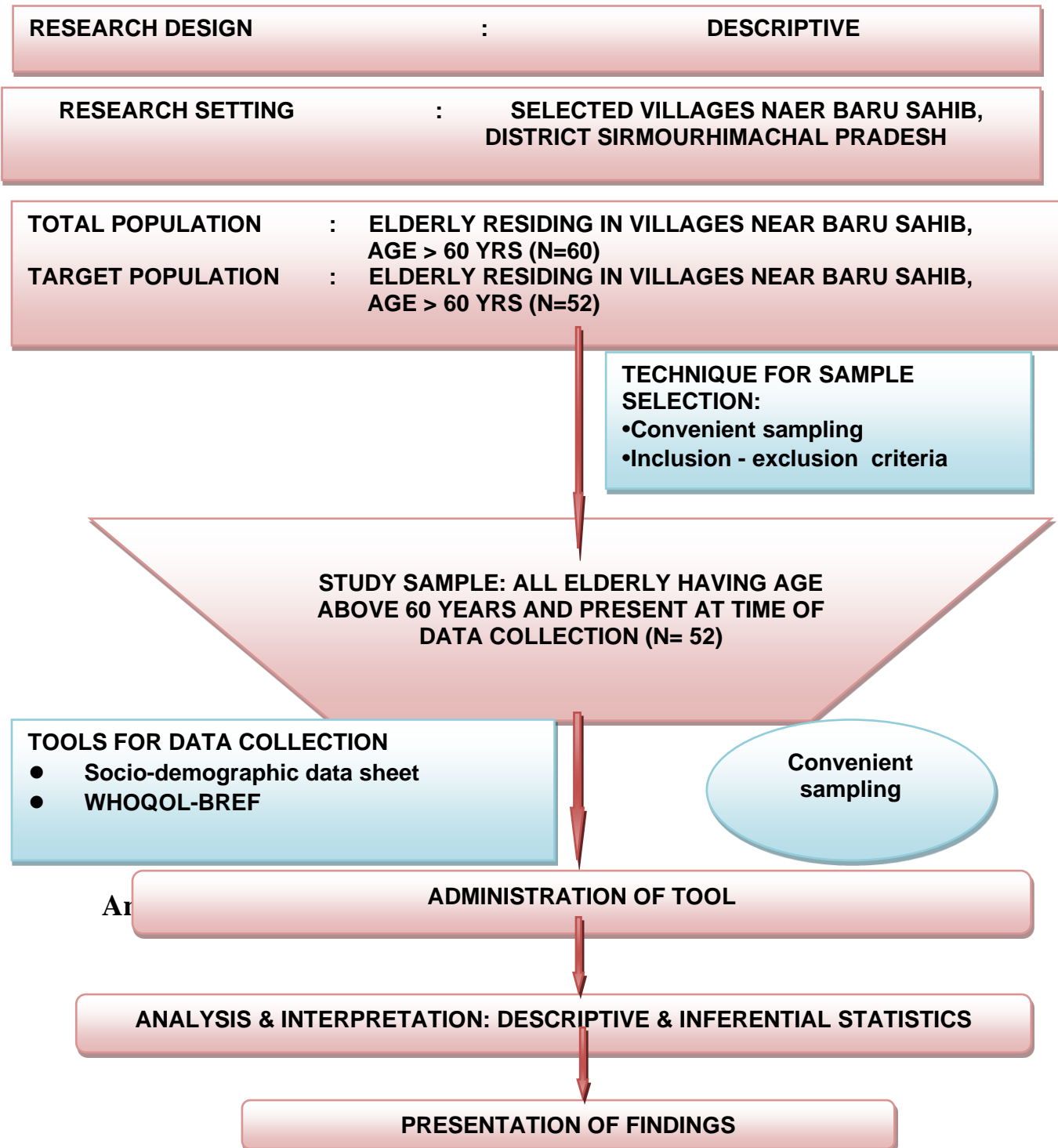
This study explored associations between quality of life (QOL), spirituality, social integration, chronic diseases, and lifetime adversity among people aged 60 years and older in Bhutan. Adults aged 60 to 101 years (n = 337) completed face-to-face interviews. The main measure included the World Health Organization QOL questionnaire and Adverse Childhood Experiences International Questionnaire. Compared with women, men reported fewer physical and mental health problems and better QOL. Multivariate analysis revealed that cumulative health problems, psychological distress, and social connectedness contributed significantly to overall QOL. The measure of spirituality was negatively associated with QOL, The significance of these findings is discussed in relation to care for elderly people in Bhutan^[8]

Indicators to assess quality of life

Allardt (1993) proposed a richer and more inclusive theoretical approach to quality of life based on meeting certain basic needs of individuals. According to his approach a person can achieve quality of life by meeting three basic sets of needs: (1) “having” which refers to material conditions that are necessary for survival and for avoidance of misery (e.g. income, housing,) (2) “loving”, defined as needs which relate to other people and to form social identities (e.g. contacts in a local community, family, friendships) (3) “being” which stands for the need for integration into society and to live in harmony with nature (e.g. involvement in political activities, leisure activities, engaging in meaningful work specifically highlighted the importance of including both subjective evaluations of people

RESEARCH METHODOLOGY

FIGURE 1



ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of data collected to assess the Quality of life' of elderly population residing the villages near Baru Sahib. The data has been analyzed and interpreted in the light of the objectives and hypothesis of the study. This section deals with the description of the demographic characteristics of elderly population residing in the villages near Baru Sahib and has been presented in the form of frequency and percentage

Table 1: Socio Demographic Profile of the Subjects

N=52

Variable	f(%)
Age (in years)	
60-70	29(55.8)
71-80	19(36.5)
81-90	2(3.8)
91-100	2(3.8)
Gender	
Male	24(46.2)
Female	27(51.9)
Educational status	
Literacy	7(13.5)
Illiterate	33(63.5)
Primary	10(19.2)
Secondary/higher	2(3.8)
Marital status	
Married	36(69.2)
Unmarried	1(1.9)
Divorced	1(1.9)
Widow	14(26.9)
Religion	
Hindu	46(88.5)
Sikh	5(9.6)
Others	1(1.9)
Type of family	
Nuclear	35(67.3)
Joint	17(32.7)
State of Domicile	
Himachal	48(92.3)

Punjab	4(7.7)
Occupation	
Agriculture	49(94.2)
Private job	1(1.9)
Others	1(3.8)
Financial resources at present	
Agriculture	29(55.8)
Pension	18(34.6)
Children	3(5.8)
Savings/property	2(3.8)
Number of total children*	
Unmarried male children	(11.5)
Unmarried female children	(7.7)
Married female children	(67.3)
Married male children	(13.5)
Diet	
Vegetarian	25(49.0)
Non-vegetarian	24(47.1)
Eggetarian	1(2.0)
Lacto-vegetarian	1(2.0)

Data in table 1 show that frequency percentage distribution of elderly population according to their age shows that highest percentage (55%) of the samples were in the age group of 60-70 years, about 36% of the respondents were in the age group of 71 – 80 and 3% of 81-90 years of age, and 3% of them were within the age group of 91-100 years.

Distribution of elderly population with their gender shows that 51% samples were females and 46% of the participants were males. Analysis related to assessing the quality of life of the samples revealed maximum (63%) of them were illiterate, (19%) of them were primary pass, (13%) of them were literate (3.8%) of them were secondary/higher. Distribution of elderly population with their state of domicile shows that maximum (92.7%) of them are from himachal only and only (7.7%) of them from Punjab. Distribution of elderly population with their habitats shows that most of (100%) samples were lives in rural area, only (0%) in urban. Analysis regarding the occupation revealed that maximum (94.2%) samples having agriculture the source of income, (3.8%) having others job and only (1.9%) having private job.

Distribution of percentage regarding their financial resources at present revealed that (55.8%) having agriculture as a resource, (34.6%) having pension, (5.8%) having children and

only (3.8%) having saving and property. Percentage distribution of number of children among the elderly population revealed that (67.3%) of elderly population having married female children, (13.5%) having married male children, (11.5%) having unmarried male children and (7.7%) having unmarried female children. Percentage distribution regarding their diet of elderly population that (49%) of them are vegetarian, (47.1%) are non-vegetarian, (2.0%) of them are egg-eater and (2.0%) of them are lacto-vegetarian.

Figure 2: line diagram showing distribution of the sample accordingly assessment of quality of life among elderly population.

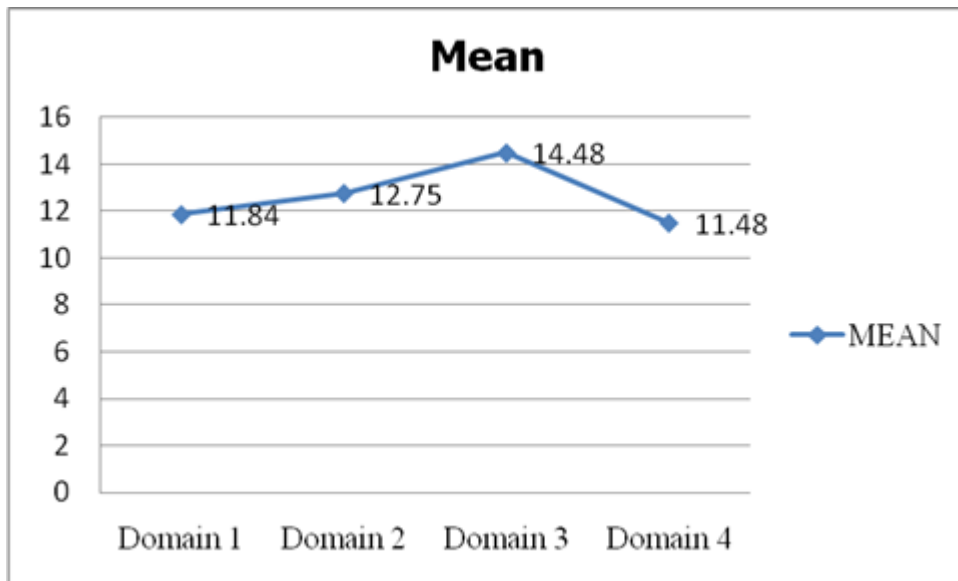


Table 3: Range of four domain of quality of life (Min-Max)

Domains	Range	Min.	Max.
Domain 1	21.00	1.20	22.20
Domain 2	44.80	1.60	46.40
Domain 3	20.10	1.20	21.30
Domain 4	16.00	1.50	17.50

The Data in table 3 shows that range of four domains of quality of life which includes

min. and max. Value. Then the range of domain1 is 21.00 (the min value is 1.20, max value is 22.20), domain 2 is 44.80 (min is 1.60 and max is 467.40), domain 3 is 20.10 (min is 1.20 and max is 21.30), domain 4 is 16.00 (min is 1.50 and max is 17

Association between Assessment Of Elderly Population And Demographic Variables.

Table 4 : chi square value of domains with respect to demographic variables

N=52

Variable	Domain 1	Domain 2	Domain 3	Domain 4
Age	$X^2=15.4$ df =6 p =.017	$X^2=9.30$ df =6 p =.157	$X^2=5.13$ df =12 p =.509	$X^2=9.24$ df =9 p =.449
Gender	$X^2=3.09$ df =4 p =3.09	$X^2=1.77$ df =4 p =.777	$X^2=5.15$ df =8 p =.646	$X^2=1.70$ df =6 p =.937
Educational status	$X^2=6.89$ df =6 p =.330	$X^2=4.17$ df =6 p =.653	$X^2=12.3$ df =12 p =.384	$X^2=8.55$ df =9 p =.453
Marital status	$X^2=1.24$ df =6 p =.975	$X^2=1.23$ df =6 p =.975	$X^2=9.93$ df =12 p =.390	$X^2=2.71$ df =9 p =.947
Religion	$X^2=1.01$ df =4 p =.841	$X^2=1.16$ df =4 p =.901	$X^2=4.13$ df =8 p =.434	$X^2=5.41$ df =6 p =.525
Type of family	$X^2=3.63$ df =2 p =.162	$X^2=1.35$ df =2 p =.508	$X^2=7.34$ df =4 p =.100	$X^2=4.71$ df =3 p =.107
State of domicile	$X^2=.907$ df =2 p =.635	$X^2=.674$ df =2 p =.714	$X^2=10.1$ df =4 p =.037	$X^2=1.03$ df =3 p =.729
Occupation	$X^2=25.7$ df =4 p =.000	$X^2=.495$ df =4 p =.974	$X^2=2.31$ df =8 p =.967	$X^2=.758$ df =6 p =.987
Financial resources at	$X^2=7.60$ df =6	$X^2=3.44$ df =6	$X^2=12.8$ df =12	$X^2=4.52$ df =9

present	p =.269	p =.751	p =.278	p =.843
Number of total children	$X^2=1.06$ df =6 p =.807	$X^2=1.04$ df =6 p =.091	$X^2=.674$ df =12 p =.716	$X^2=.912$ df =9 p =.677
Diet	$X^2=1.14$ df =6 p =.965	$X^2=.141$ df =6 p =.861	$X^2=7.21$ df =12 p =.288	$X^2=1.21$ df =9 p =.178

Table 4 signifies that the obtained chi-square values of four domains is less than 0.05 than the table value at 0.05 which indicates that there is no significant association between assessment score and quality of life of the elderly people.

DISCUSSION

The result and discussion of the study is the researcher's opportunities to examine the logic of theoretical framework, methods and analysis.

The findings of the study were organized and presented according to objectives of the study under the following sections:

1. Description of the demographic variables of B.Sc. Nursing students.
2. Findings related to knowledge of quality of life in elderly.
 - a) Findings related to the pre-test knowledge about quality of life in elderly.
 - b) Findings related to post-test knowledge about quality of life in elderly.
 - c) Comparison of pre-test and post-test knowledge about quality of life in elderly.
- 3 Findings related to the association between post test knowledge score of elderly with selected demographic variables

The result of first national survey in 1998 on health and ageing in Iran showed that the employment rate was 42-64% among males whereas just 2.7-9.3 females were paid employed. Our findings revealed that 70-80% males were employed whereas 20% females were employed.

The study shows the physical domain score was 61.95 ± 70.72 among 60-69 years as compared to 55.18 ± 90.71 amongst geriatric above 70 years in rural areas the psychological domain score amongst rural elderly between 60-69 years was 55.08 ± 8.48 as compared to 50.78 ± 7.26 in those above 70 years of age . In the present study shows the physical domain

score was 11.8 among 60-69 years and psychological domain score is 14.48 among 60-69 years.

CONCLUSION

The study conducted to assess the quality of life in elderly population has been concluded in the following domains where domain 1 is related to physical aspect, domain 2 relating to psychological aspect followed by domain 3 with social aspect whereas domain 4 relates to the environmental aspect. Score for domain 1 is 11.84 ± 3.08 , domain 2 is 12.75 ± 5.47 , domain 3 is 14.48 ± 3.68 and domain 4 is 11.48 ± 3.36 . Therefore, the subjects have shown better results in Domain 3 representing the social aspects in terms social interactions, daily living, diet, working.

LIMITATIONS

- 1) Data collection was difficult because people were residing in very secluded places with no transportation.
- 2) Data collection was time consuming.
- 3) Subjects show stubborn behaviour .

RECOMMENDATION

- 1) A similar study can be conducted/replicated on large scale .
- 2) A comparative study can be conducted to assess the quality of life in rural and urban areas.

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