

Original Research Article

Prospective evaluation of quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru

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Received: 10 March 2026

Revised: 05 September 2026

Accepted: 09 September 2026

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ABSTRACT

Background: Type 2 diabetes mellitus (T2DM) is one of the most prevalent non-communicable diseases globally and poses a significant public health challenge, particularly in developing countries like India. The chronic nature of the disease, along with its complications and long-term treatment requirements, can substantially affect patients' quality of life (QoL).

Methods: A community-based prospective observational study was conducted among 390 adults with type 2 diabetes mellitus residing in selected urban slums of Bengaluru from February 2025 to January 2026. Participants were selected using simple random sampling. Quality of life was assessed using the WHOQOL-BREF questionnaire. Data were analyzed using SPSS version 26. Descriptive statistics and inferential tests such as chi-square test were applied, with $p < 0.05$ considered statistically significant.

Results: The mean age of participants was 52.3 ± 10.8 years. The physical health domain had the lowest mean QoL score (54.3 ± 11.6), while the social relationships domain showed the highest score (60.2 ± 12.4). Overall, 56.9% of participants had poor quality of life. Significant associations with poor QoL were observed for age > 50 years ($OR = 1.85$), female gender ($OR = 1.84$), diabetes duration > 5 years ($OR = 2.27$), presence of complications ($OR = 2.79$), and lower socioeconomic status ($OR = 4.16$) ($p < 0.05$).

Conclusions: More than half of the diabetic patients living in urban slums had poor quality of life. Older age, female gender, longer disease duration, diabetic complications, and low socioeconomic status were key determinants of reduced QoL.

Keywords: Bengaluru, Quality of life, Socioeconomic factors, Type 2 diabetes mellitus, Urban slums, WHOQOL-BREF

INTRODUCTION

Diabetes Mellitus is one of the most common and rapidly increasing non-communicable diseases worldwide and represents a major public health concern. Among its different types, type 2 diabetes mellitus (T2DM) accounts for nearly 90-95% of all diabetes cases and is primarily characterized by insulin resistance and impaired insulin secretion, leading to persistent hyperglycemia. Over the past few decades, the prevalence of diabetes has increased dramatically due to rapid urbanization, sedentary

lifestyles, dietary changes, increasing obesity, and aging populations. According to the International Diabetes Federation (IDF), approximately 537 million adults were living with diabetes globally in 2021, and this number is projected to rise to 643 million by 2030 and 783 million by 2045, indicating a substantial global health burden. India is among the countries with the highest number of individuals affected by diabetes, and the prevalence continues to increase in both urban and rural populations. Consequently, India is often referred to as the "diabetes capital of the world," highlighting the urgent need for effective prevention and management strategies.¹

T2DM is associated with several long-term complications that significantly affect an individual's health and well-being. Chronic hyperglycemia can lead to both microvascular and macrovascular complications such as diabetic retinopathy, nephropathy, neuropathy, cardiovascular diseases, and peripheral vascular disease. These complications contribute to increased morbidity, disability, and healthcare costs. Beyond its physical effects, diabetes also imposes a substantial psychological and social burden on affected individuals. Patients are required to adhere to long-term treatment regimens, lifestyle modifications, dietary restrictions, and regular monitoring of blood glucose levels. These factors can negatively affect daily functioning, emotional well-being, and social interactions, thereby influencing overall quality of life.²

In recent years, the concept of quality of life (QoL) has gained increasing importance in the management of chronic diseases such as diabetes. Quality of life refers to an individual's perception of their position in life within the context of culture, value systems, personal goals, expectations, and concerns. It encompasses multiple dimensions including physical health, psychological well-being, social relationships, and environmental conditions. Assessment of quality of life provides valuable insights into how chronic diseases affect patients beyond clinical parameters such as blood glucose levels or HbA1c. Understanding these broader impacts is essential for developing patient-centered care strategies that address both medical and psychosocial needs.³

Various standardized instruments have been developed to assess quality of life in patients with chronic diseases. Among them, the WHOQOL-BREF questionnaire developed by the World Health Organization is widely used. It evaluates four major domains of quality of life: physical health, psychological health, social relationships, and environmental factors. These domains provide a comprehensive understanding of how individuals perceive their health and overall well-being. Assessing quality of life using such validated tools is particularly important in chronic diseases like diabetes, where long-term management and self-care play a crucial role in determining health outcomes.⁴

Urbanization has been recognized as a major driver of the diabetes epidemic, particularly in developing countries. Rapid urban growth has led to significant lifestyle changes, including reduced physical activity, increased consumption of calorie-dense foods, and higher stress levels. Within urban settings, populations residing in slum areas represent a particularly vulnerable group. Urban slums are often characterized by overcrowding, poor housing conditions, limited access to healthcare services, low socioeconomic status, and inadequate health awareness. These social determinants of health can adversely influence the prevention, management, and outcomes of chronic diseases such as diabetes.⁵

In metropolitan cities such as Bengaluru, the expansion of urban slums has been accompanied by an increasing burden of non-communicable diseases, including diabetes. Individuals living in these communities frequently face barriers to healthcare access, irregular treatment, financial constraints, and limited opportunities for lifestyle modification. These challenges may further compromise disease control and adversely affect their quality of life. Despite the growing prevalence of diabetes among urban poor populations, relatively few studies have prospectively evaluated the quality of life of individuals with T2DM residing in urban slum settings.

A better understanding of the impact of diabetes on quality of life among urban slum residents is essential for designing targeted community-based interventions and improving healthcare delivery. Prospective studies provide valuable insights into the evolving challenges faced by patients over time and help identify factors that influence their well-being. Therefore, the present study was undertaken to prospectively evaluate the quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru. The findings of this study may contribute to the development of effective public health strategies aimed at improving diabetes management and enhancing the overall well-being of individuals living in underserved urban communities.

Objectives

The present study aimed to evaluate the quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru. It also seeks to assess the different domains of quality of life- physical health, psychological health, social relationships, and environmental health- using the standardized WHOQOL-BREF questionnaire. The objectives of the study were to evaluate the relationship between clinical characteristics of diabetes, including duration of disease, treatment modality, and presence of complications, with the quality of life of the affected individuals. The study also intended to identify factors that influence poor quality of life among patients with type 2 diabetes mellitus living in urban slum communities.

METHODS

Study design

The present study was a community-based prospective observational study conducted to evaluate the quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru.

Study setting

This study was conducted in selected urban slums located in Bengaluru city, Karnataka. These areas are characterized by high population density, lower socioeconomic status, and limited access to healthcare

facilities. The selected urban slums fall under the field practice area of Rajarajeswari Medical College and Hospital.

Study population

The study population included adult patients diagnosed with type 2 diabetes mellitus who are residing in the selected urban slum areas of Bengaluru. Individuals who have been diagnosed with type 2 diabetes mellitus by a registered medical practitioner and are currently receiving treatment or follow-up care will be eligible for inclusion.

Study duration

The study was conducted over a period of one year. It was initiated in February 2025 and ended in January 2026. In this duration, we did participant recruitment, baseline data collection, follow-up assessment, and evaluation of quality of life among the study participants.

Sample size

The sample size was calculated using the standard formula for estimating a proportion in community-based studies. A previous study conducted by Jannoo et al reported that approximately 52% of patients with type 2 diabetes had poor quality of life based on WHOQOL assessment.⁶ Therefore, the value of $p=52\%$ (0.52) was used for the calculation. Allowable error was taken as 10% of p . Considering a 10% non-response rate, the final sample size of 390 was considered.

Sampling method

Simple random sampling technique was used to recruit eligible participants from the urban slum population. A list of known diabetic patients was obtained from local health centers, community health workers and health registers which were maintained under national health programs. Participants fulfilling the inclusion criteria were approached and enrolled in the study after obtaining informed consent.

Inclusion and exclusion criteria

Adults aged 18 years and above diagnosed with type 2 diabetes mellitus and residing in the selected urban slum areas for at least six months were included in the study. Individuals who are willing to participate and provide informed consent were enrolled.

Patients with severe mental illness, critically ill individuals who are unable to respond to the questionnaire and those suffering from other serious chronic illnesses that may independently affect quality of life were excluded from the study. The participants who withdrew consent at later stages were also excluded from the study.

Data collection tools and technique

Data was collected using a pre-tested semi-structured questionnaire. The questionnaire included information on socio-demographic variables such as age, gender, education, occupation, and socioeconomic status. Clinical characteristics including duration of diabetes, treatment modality and presence of complications were also recorded. Quality of life was assessed using the standardized WHOQOL-BREF questionnaire developed by the World Health Organization. This validated instrument evaluates quality of life across four domains: physical health, psychological health, social relationships, and environmental health, and has been widely used in studies involving patients with chronic diseases including diabetes.⁴

Data collection procedure

Eligible participants were identified through community surveys and records maintained by local healthcare providers or health workers. After explaining the objectives of the study, written informed consent was obtained from the participants. Face-to-face interviews was conducted using the study questionnaire. The WHOQOL-BREF tool was administered according to standard guidelines, and domain scores were calculated following recommended scoring procedures.⁴

Statistical analysis

The collected data was entered into Microsoft Excel and analyzed using SPSS v26. Descriptive statistics including frequency, percentage, mean, and standard deviation are used to summarize the socio-demographic and clinical characteristics of the participants. Quality of life scores in different domains are calculated and compared across different groups. Inferential statistical tests such as chi-square test, independent t-test and analysis of variance (ANOVA) are applied to determine associations between independent variables and quality of life outcomes. A p value of less than 0.05 is considered statistically significant.⁷

Ethical considerations

Ethical approval was obtained from the institutional ethics committee prior to the commencement of the study. Written informed consent was obtained from all participants after explaining the purpose and procedures of the study. Confidentiality and privacy of participant information is strictly maintained throughout the research process in accordance with ethical guidelines for biomedical research involving human participants.⁸

RESULTS

A total of 390 participants diagnosed with type 2 diabetes mellitus residing in urban slums of Bengaluru were included in the study. The mean age of the study

participants was 52.3 ± 10.8 years, with the majority of participants belonging to the 51-60 years age group.

Socio-demographic characteristics

Table 1 shows the socio-demographic characteristics of the study participants. Among the 390 participants, 132 (33.8%) belonged to the 51-60 years age group, followed

by 102 (26.2%) in the 41-50 years age group, 98 (25.1%) above 60 years, and 58 (14.9%) in the 30-40 years age group.

With regard to gender distribution, 208 (53.3%) were males and 182 (46.7%) were females, indicating a slightly higher proportion of male participants in the study population.

Table 1: Socio-demographic characteristics of study participants (n=390).

Variables	Category	Frequency	Percentage
Age (years)	30-40	58	14.9
	41-50	102	26.2
	51-60	132	33.8
	>60	98	25.1
Gender	Male	208	53.3
	Female	182	46.7
Education	Illiterate	96	24.6
	Primary	142	36.4
	Secondary	110	28.2
	Graduate and above	42	10.8
Occupation	Unemployed	82	21.0
	Unskilled worker	164	42.1
	Skilled worker	96	24.6
	Professional	48	12.3
Socioeconomic status	Lower	172	44.1
	Lower middle	144	36.9
	Upper middle	74	19.0

Table 2: Clinical characteristics of diabetes among study participants (n=390).

Variables	Category	Frequency	Percentage
Duration of diabetes	<5 years	152	39.0
	5–10 years	148	37.9
	>10 years	90	23.1
Treatment modality	Oral hypoglycemic drugs	248	63.6
	Insulin therapy	96	24.6
	Both	46	11.8
Presence of complications	Yes	138	35.4
	No	252	64.6

In terms of educational status, the majority of participants had primary level education (36.4%), followed by secondary education (28.2%), while 24.6% were illiterate and only 10.8% were graduates or above.

Regarding occupation, unskilled workers constituted the largest group (42.1%), followed by skilled workers (24.6%), unemployed individuals (21.0%), and professionals (12.3%).

Assessment of socioeconomic status revealed that 44.1% of participants belonged to the lower socioeconomic class, 36.9% to the lower middle class, and 19.0% to the upper middle class.

Clinical characteristics of diabetes

The clinical characteristics of diabetes among the participants are presented in Table 2. Nearly 39.0% of participants had diabetes for less than 5 years, while 37.9% had diabetes for 5-10 years, and 23.1% had diabetes for more than 10 years.

Regarding treatment modality, 248 participants (63.6%) were on oral hypoglycemic drugs, 96 participants (24.6%) were receiving insulin therapy, and 46 participants (11.8%) were receiving both oral drugs and insulin.

The presence of diabetes-related complications was reported in 138 participants (35.4%), whereas 252 participants (64.6%) had no complications at the time of the study.

Quality of life scores

The mean scores of the different domains of quality of life assessed using the WHOQOL-BREF questionnaire are presented in Table 3. The social relationships domain had the highest mean score (60.2±12.4), followed by the environmental domain (58.6±11.2) and the psychological domain (57.8±10.9). The physical health domain had the lowest mean score (54.3±11.6) among the participants.

Table 3: Quality of life domains (WHOQOL-BREF scores).

Domains	Mean score±SD
Physical health	54.3±11.6
Psychological health	57.8±10.9
Social relationships	60.2±12.4
Environmental health	58.6±11.2

Overall quality of life

Table 4 shows the overall quality of life among the participants. More than half of the participants, 222 (56.9%), were found to have poor quality of life, whereas 168 participants (43.1%) had good quality of life.

Table 4: Overall quality of life among participants.

Quality of Life	Frequency	Percentage
Good QoL	168	43.1
Poor QoL	222	56.9

Association between selected variables and quality of life

The association between selected socio-demographic and clinical variables and quality of life is shown in Table 5.

Age showed a statistically significant association with quality of life ($\chi^2=6.42$, $p=0.011$). Participants aged more than 50 years were 1.85 times more likely to have poor quality of life compared to those aged 50 years or below (OR=1.85; 95% CI: 1.20-2.86).

Gender was also significantly associated with quality of life ($\chi^2=7.38$, $p=0.006$). Female participants had 1.84 times higher odds of poor quality of life compared to males (OR=1.84; 95% CI: 1.20-2.82).

Duration of diabetes showed a strong association with quality of life ($\chi^2=16.32$, $p<0.001$). Participants with diabetes duration greater than 5 years had 2.27 times higher odds of poor quality of life compared to those with shorter duration (OR=2.27; 95% CI: 1.49-3.45).

Presence of diabetes-related complications was significantly associated with quality of life ($\chi^2=20.51$, $p<0.001$). Participants with complications had 2.79 times higher odds of poor quality of life compared to those without complications (OR=2.79; 95% CI: 1.76-4.42).

Socioeconomic status also showed a statistically significant association with quality of life ($\chi^2=24.67$, $p<0.001$). Participants belonging to the lower socioeconomic class were 4.16 times more likely to have poor quality of life compared to those belonging to the upper or lower middle socioeconomic classes (OR=4.16; 95% CI: 2.61-6.62).

Table 5: Association between selected variables and quality of life.

Variables	Groups	Poor QoL (%)	Good QoL (%)	χ^2	P value	OR (95% CI)
Age in years	≤50	78 (48.1)	84 (51.9)	6.42	0.011	1
	>50	144 (63.2)	84 (36.8)			1.85 (1.20-2.86)
Gender	Male	104 (50.0)	104 (50.0)	7.38	0.006	1
	Female	118 (64.8)	64 (35.2)			1.84 (1.20-2.82)
Duration of diabetes	≤5 years	68 (44.7)	84 (55.3)	16.32	<0.001	1
	>5 years	154 (64.7)	84 (35.3)			2.27 (1.49-3.45)
Complications	No	122 (48.4)	130 (51.6)	20.51	<0.001	1
	Yes	100 (72.5)	38 (27.5)			2.79 (1.76-4.42)
Socio economic class	Upper/lower middle	92 (42.6)	124 (57.4)	24.67	<0.001	1
	Lower	130 (75.6)	42 (24.4)			4.16 (2.61-6.62)

DISCUSSION

The present community-based prospective study evaluated the quality of life (QoL) among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru using the WHOQOL-BREF instrument.

In the present study, the mean age of participants was 52.3±10.8 years, with the majority belonging to the 51-60 years age group (33.8%). This finding is consistent with the study conducted by Amin et al, where the majority of patients with type 2 diabetes were middle-aged or older adults.⁹ The study also found that 53.3% of participants

were male, which is comparable to several hospital-based and community studies where males constituted a slightly higher proportion of diabetic patients.

The clinical characteristics of the participants revealed that 39% had diabetes for less than 5 years, while 37.9% had diabetes for 5-10 years and 23.1% had diabetes for more than 10 years. Similar findings were reported in studies assessing quality of life among diabetic patients, where a substantial proportion had long-standing diabetes. Longer disease duration is often associated with increased risk of complications and poorer quality of life.¹⁰ A study by Redekop et al demonstrated that patients with longer disease duration experienced significantly lower quality of life scores due to the cumulative burden of diabetes-related complications and treatment requirements.¹¹

In the present study, 35.4% of participants had diabetes-related complications, while 64.6% had no complications. Previous studies have demonstrated that the presence of complications is strongly associated with poorer health-related quality of life among diabetic patients.¹²

Assessment of the four domains of quality of life using WHOQOL-BREF showed that the social relationships domain had the highest mean score (60.2 ± 12.4), followed by environmental (58.6 ± 11.2) and psychological domains (57.8 ± 10.9), while the physical health domain had the lowest mean score (54.3 ± 11.6). Similar findings were reported in studies conducted in Indonesia and other developing countries, where the physical domain often showed the lowest QoL scores due to the physical burden of diabetes and associated complications.¹³ Furthermore, WHOQOL-BREF studies in diabetes populations have demonstrated that the social and psychological domains may remain relatively better preserved when patients receive adequate family support and community interaction.

The present study found that 56.9% of participants had poor quality of life, while 43.1% had good quality of life. These findings are comparable to studies conducted in various countries where a large proportion of diabetic patients reported reduced quality of life due to chronic disease burden and treatment demands. Poor quality of life among diabetic patients may be attributed to multiple factors including chronic disease duration, complications, lifestyle restrictions, financial burden, and psychosocial stress associated with long-term disease management. Studies have emphasized that reduced quality of life can adversely affect self-care behaviors and glycemic control, thereby worsening long-term outcomes.

The present study demonstrated a significant association between age and quality of life ($p=0.011$), with individuals aged more than 50 years having 1.85 times higher odds of poor quality of life. Similar findings were reported in several studies where increasing age was

associated with declining quality of life due to increased disease burden and higher prevalence of complications.¹¹

Gender also showed a statistically significant association with quality of life ($p=0.006$), with female participants having higher odds of poor quality of life compared to males. This observation has been reported in several studies where women with diabetes experienced lower QoL scores due to greater psychosocial stress, limited healthcare access, and caregiving responsibilities.¹⁴

Duration of diabetes was another important determinant of quality of life in this study. Participants with disease duration greater than 5 years had significantly higher odds of poor quality of life ($OR=2.27$). This finding is consistent with the study by Glasgow et al, which reported that longer disease duration was associated with poorer health-related quality of life due to increased treatment burden and higher risk of complications.¹⁴

Similarly, the presence of diabetes-related complications showed a strong association with poor quality of life ($p<0.001$). Participants with complications were 2.79 times more likely to have poor quality of life. Similar results were reported in a study conducted by Rwegerera et al, which demonstrated that diabetic complications significantly reduced quality of life scores across multiple domains.¹⁵

Socioeconomic status also had a significant impact on quality of life in the present study ($p<0.001$). Participants belonging to the lower socioeconomic class had more than four times higher odds of poor quality of life compared to those from higher socioeconomic groups. Similar associations have been reported in studies conducted in developing countries, where economic constraints limit access to healthcare services, medications, and healthy lifestyle practices.

CONCLUSION

The present community-based prospective study evaluated the quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru using the WHOQOL-BREF questionnaire. The findings of the study revealed that more than half of the participants had poor quality of life, indicating a considerable impact of diabetes on the overall well-being of individuals living in urban slum communities.

Among the different domains of quality of life, the physical health domain showed the lowest mean score, suggesting that the physical burden of diabetes and its associated complications significantly affect daily functioning. In contrast, relatively better scores were observed in the social and environmental domains, possibly reflecting the supportive community environment often present in urban slum settings.

The study also identified several factors that were significantly associated with poor quality of life. Older age, female gender, longer duration of diabetes, presence of diabetic complications, and lower socioeconomic status were found to be important determinants of reduced quality of life among the study participants. These findings highlight the multidimensional nature of diabetes and the influence of both clinical and socio-demographic factors on patient well-being.

Overall, the results emphasize the need for comprehensive diabetes management strategies that extend beyond glycemic control and address the broader aspects of patient health, including physical, psychological, and social well-being. Strengthening community-based diabetes care, improving health education, early detection and management of complications, and enhancing access to healthcare services may help improve the quality of life of individuals living with diabetes, particularly among vulnerable populations residing in urban slums.

Further community-based interventions focusing on patient education, lifestyle modification, and regular monitoring are essential to improve long-term outcomes and enhance the overall quality of life among patients with type 2 diabetes mellitus.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Gowda H, Durai V, Sabarinath, Dhal NK. Prospective evaluation of quality of life among patients with type 2 diabetes mellitus residing in urban slums of Bengaluru. *Int J Community Med Public Health* 2026;13:5716-22.