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Original Research Article

Assessment of quality of life of geriatric population in Nawabganj, Unnao

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ABSTRACT

Background: The quality of life (QOL) among geriatrics is a neglected issue especially in developing countries including India. It is a broad-ranging concept affected in a complex way by the individual's physical health, psychological state, level of independence, social relationships, and their relationships to the environment. The study was done to assess the QOL and morbidity patterns of people aging 60 or above in urban Nawabganj, Unnao and to correlate the QOL with various sociodemographic factors.
Methods: A community based cross-sectional study was conducted among 220 elderly subjects in urban field practice area of Saraswati Medical College, Unnao from February to April 2018. The data on QOL was assessed by World Health Organization Quality of Life BREF (WHOQOL-BREF). The socio-demographic characteristics and morbidity conditions were recorded by using structured questionnaire. The independent sample t test was used to compare the mean scores.
Results: A total of 220 subjects participated in the study. Majority (64.09%, 141) were in the 60-69 years' age-group. Around 40% of the total was males and 64.54% (142) were literate. About 2/3 of them 62.72%, (138) lived with their partners and 66.81% (147) lived in nuclear families. The most common morbidity was musculoskeletal problems (44.54%) followed by hypertension (36.81%) and diabetes (28.63%). The independent t-test showed that QOL was significantly low among those in illiterate, those living in nuclear families and those living separate, widow/widower and divorced.
Conclusions: The quality of life score of geriatric population was found to be average with the lowest score in social relationships.

Keywords: Geriatric, Quality of life, Unnao

INTRODUCTION

The World Health Organization (WHO) has defined quality of life (QOL) as "an individual's perception of life in the context of culture and value system in which he or she lives and in relation to his or her goals, expectations, standards, and concerns".[1] In recent years, quality of life instruments have been acknowledged as very important in the evaluation of health care.[2] It is a broad-ranging concept affected in a complex way by the individual's physical health, psychological state, level of independence, social relationships, and their relationships to salient features of their environment".[3] There are many general instruments available to measure quality of life. The World Health Organization (WHO) has developed a quality of life instrument, the WHOQOL, which captures

many subjective aspects of quality of life).[4-6] The WHOQOL-BREF is one of the best-known instruments that has been developed for cross-cultural comparisons of quality of life and is available in more than 40 languages.[7,8]

Aging is generally defined as a process of deterioration in the functional capacity of an individual that results from structural changes, with advancement of age.[9] Longevity must come along with the quality, then and then feeling of contentment could be achieved. By 2020, for the first time in history, the number of people aged 60 years and older will outnumber children younger than 5 years. By 2050, the world's population aged 60 years and older is expected to total 2 billion, up from 841 million today.[10] The rapidly growing numbers of older peoples' population in both developed and developing countries mean that they all would be at risk of a challenge to their QOL. The challenge in the 21st century is to delay the onset of disability and ensure optimal QOL for older people.[11] The present study was conducted to study the quality of life of geriatrics in the urban field practice area of the department of community medicine of Saraswati Medical College, Unnao with the objectives to study the QOL and morbidity patterns of people aging 60 or above in urban Nawabganj, Unnao and to study the relationship of QOL of geriatric population with various sociodemographic factors.

METHODS

This was a community based cross sectional study in the field practice area of the department of community medicine of Saraswati Medical College, Nawabganj, Unnao from February 2018 to April 2018. The persons of age 60 years and above were the study subjects. The people who did not give consent for the participation were excluded from the study.

The study was conducted in geriatric population in the field practice area. The total population of the field practice area is around 9200 out of which 493 belong to the age group > 60 years which is around 5.35% of the total population. At 95% confidence interval with 5% margin of error and a total geriatric population of approx. 500, the required sample size is 217 and adding 10% non-response rate, the sample size becomes 237.

A predesigned questionnaire related to the QOL of elderly people devised by the WHO (WHOQOL) was used for the survey.[1] The questionnaire was translated in local language. It takes into consideration following domains of QOL i.e., physical, psychological, environmental and social relationships.

Out of a total of 237, only 220 participated in the study with a response rate of 92.82% and the remaining were non-respondents. If the designated subjects were not available even after 2 visits, they were considered as non-respondents. Data on socio demographic characteristics that include age, sex, education, family type and marital status were collected using a structured questionnaire. The morbidity status was assessed based on the previous diagnosis by a registered medical practitioner. The data was collected by house-to-house visits. The informed consent was taken from participants before initiation of the study. Taking into consideration of the variable literacy status, a structured interview was carried out to fill up the questionnaire from each of the respondent. The data was entered and analyzed using SPSS version 18. The findings were expressed in terms of mean and standard deviation (SD). The difference between the mean scores was tested by using independent sample t-test. P value less than 0.05 was considered as significant.

Operational definitions

Literate

Any person aged seven years or more who can write and understand any one scheduled language.

Married

Any person who was married and living with their partners.

Others

Any person who was living separate, widow/widower and divorced.

Nuclear family

The family consisted of husband and wife, with or without unmarried children residing under same roof and sharing the same kitchen.

Joint family

Family of siblings are living together. The family consisted of father, mother plus unmarried sisters and/or brothers or husband, wife and their married children, etc.

Morbidity status

Assessed based on the previous diagnosis by registered medical practitioner. The category "Others" includes skin diseases, dental problems, acidity, genitourinary problems etc.

RESULTS

The response rate was 92.82%, out of 237 subjects. A total of 220 subjects participated in the study. Majority (64.09%, 141) were in the 60-69 years' age-group. About 40% (88) of them were males. Of the total, 64.54% (142) were literate. About 2/3 of them 62.72%, (138) lived with their partners and 66.81% (147) lived in nuclear families.

Table 1 shows the socio-demographic characteristics of the study participants.

Table 1: Socio-demographic characteristics of study population (n=220).

Socio-demographic characteristics		
Variables	**N**	**%**
Age (in years)		
60-69	141	64.09
≥70	79	35.90
Sex		
Male	88	40.0
Female	132	60.0
Education		
Illiterate	78	35.45
Literate	142	64.54
Family type		
Nuclear	147	66.81
Joint	73	33.18
Marital status		
With partners (married)	138	62.72
Others	82	37.27

Table 2 shows the morbidity pattern of the study subjects in the given area. The most common morbidity was musculoskeletal problems (44.54%) followed by hypertension (36.81%) and diabetes (28.63%). Seventy-three subjects (33.18%) had low vision/cataract, 5% (11) had psychological disturbances in the form of anxiety, depression or mood swings, 4.09% (9) had hearing impairment and 7.72% (17) belonged to Others.

The independent t-test showed that QOL was significantly low among those in illiterate, those living in nuclear families and those living separate, widow/widower and divorced.

Table 3 depicts the mean quality of life scores in different domains. The average quality of life score was 49.31. The maximum mean score was maximum in psychological domain and the least in social relationships.

Table 2: Morbidity status of the study population.

Morbidity pattern	N	%
Musculoskeletal problems	98	44.54
Hypertension	81	36.81
Diabetes	63	28.63
Cataract/low vision	73	33.18
Hearing impairement	9	4.09
Psychological disturbances	11	5
Others	17	7.72

Table 3: QOL scores of study population (n=220).

QOL (max. score 100)	Mean score	SD
Physical	53.21	11.21
Psychological	54.30	9.23
Social relationships	38.42	17.54
Environmental	51.31	10.28

Table 4: Relationship of QOL score with socio demographic factors.

Variables	N	%	Mean score	SD	P value
Age in years					
60-69	141	64.09	53.21	10.21	0.99
≥70	79	35.90	49.01	9.52	
Sex					
Male	89	40.45	51.54	9.54	0.97
Female	131	59.54	48.81	11.52	
Education					
Literate	142	64.54	54.36	9.31	0
Illiterate	77	35.45	41.53	8.53	
Family type					
Nuclear	147	66.81	48.41	11.52	0.01
Joint	73	33.18	51.73	9.35	
Marital status					
Married	138	61.81	43.01	10.73	0.03
Others	82	38.18	40.48	9.81	

DISCUSSION

This cross-sectional study was carried out among geriatric population residing at the field practice area of urban health training centre. A total of 220 subjects were interviewed. The females (59.54%) outnumbered males (40.45%) in the present study. Similar findings were seen in the studies carried out by Sowmiya and Nagarani and Jacob et al.[12,13] where in females were more as compared

to males. The study found that almost two-third of geriatrics were currently married and having spouses alive. The educational status of study population showed that 35.45% were illiterate.

In the present study, the most common morbidity was musculoskeletal problems (44.54%) followed by hypertension (36.81%) and diabetes (28.63%). Seventy-three subjects (33.18%) had low vision/cataract, 5% (11) had psychological disturbances in the form of anxiety, depression or mood swings, 4.09% (9) had hearing impairment and 7.72% (17) belonged to Others. Also, Jacob et al reported the musculoskeletal problems to be the most common morbidity in their study conducted in Tamil Nadu.[13] Qadri et al (64.5%) and Joshi et al found anaemia as the most common morbidity in their studies while Kishore et al reported hypertension (41.4%) as the most common morbidity.[14,15]

The study highlighted the fact that the overall QOL was average while social relationship domain of QOL showed below average score. Qadri et al, revealed that majority (68.2%) of elderly had good QOL whereas only 0.9% had poor. The mean score of social domains was maximum (69.4±9.7) as compared to other three domains. Similar presentation was seen in study by Sowmiya and Nagarani in Tamil Nadu, where the highest score was for the social relationship domain.[12] Mudey et al, in their study concluded that the QOL of rural elderly population was better in physical and psychological domain, whereas QOL in urban slum elderly was better in social relationship and environmental domain.[16] The difference observed in QOL score in different domains may be due to difference in the pattern of associated factors which influence QOL in different study settings. The study instrument used to assess QOL and urban-rural difference may be the other factors responsible for the difference in study findings.

Limitations of this study were as the study population was conducted in urban area, the generalizability of the results is low. The study included only diagnosed cases while some may be hidden cases. There may be bias in recording the information as some people tend to conceal the facts because of their own reasons.

CONCLUSION

The quality of life score of geriatric population was found to be average with the lowest score in social relationships. Social recreational activities will help in building self-image and QOL. Health education with regard to activity and environmental changes and increase in social relationship may help in improving the QOL among the elderly population.

Recommendations

It is suggested to start with a geriatric clinic with separate sessions on promotion of social recreational activities and counseling. It is recommended to conduct further analytical studies for knowing such pattern of quality of life in geriatric age group.

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