Study of Assessment of Quality of Life in Elderly Residing in Rural Area

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Abstract: *Ageing refers to the normal progressive and irreversible biological changes that occur over and individual's lifespan. Aim of the study is to assess the health status with special reference to quality of elderly in rural population. Objective of the study is to study the proportion of the elderly in the rural area. To study the morbidity status and its association, if exists, with socio-demographic factors. To assess the quality of life in rural population groups. To suggest appropriate measures for promotion of health of elderly in rural area. Methodology- A rural area adopted under Rural Health Training Centre (RHTC). Community based cross sectional study. Study population were selected All persons of age 60 years and above from rural area. Conclusion: Ageing is a universal phenomenon, with advanced fertility control, improvement in the health and social service, life expectancy has increased. Ageing has profound effect on individual status in the family, the work force, goals and organization of health, social service, policies and practices of the government.*

Keywords: quality of life, old age, rural area, aging

1. Introduction

Ageing refers to the normal progressive and irreversible biological changes that occur over and individual's lifespan. Ageing can also be defined as a state of mind, which does not always keep pace with our chronological age. The attitude and copying with normal changes, challenges and opportunities of later life may define best our age.[1]

The world's elderly population has been growing for centuries. The global population aged 65 and over was estimated to be 420 million people as of midyear 2000, an increase of 9.5 million since midyear 1993[3]. The elderly population (aged 60 years or above) account for 7.4% of total population in 2001. For males it was marginally lower at 7.1%, while for females it was 7.8%. The proportion was projected to increase up to 8.2% in 2011. Among states the proportion vary from around 4% in small states like Dadra & Nagar Haveli, Nagaland Arunachal Pradesh, Meghalaya to more than 10.5% in Kerala. According to NSSO 2007-08 proportions of the elderly in India was 7.5 and of Maharashtra state was 8.7%.[4]. The stress response can be Physical, psychological, emotional or spiritual in nature and is usually a combination of these dimensions. Stress, similarly, can arise from one or more dimensions and can be either internal or external [5]. Chronic stress takes a toll when there are additional stress factors like home stress, conflict at work, inadequate staffing, poor teamwork, inadequate training, and poor supervision. Stress is known to cause emotional exhaustion in nurses and lead to negative feelings toward those in their care [6].

Aim of the study is to assess the health status with special reference to quality of elderly in rural population.

Objective of the study is to study the proportion of the elderly in the rural area. To study the morbidity status and its association, if exists, with socio-demographic factors. To assess the quality of life in rural population groups. To suggests appropriate measures for promotion of health of elderly in rural area.

2. Methodology

Research methodology involves the systematic procedure by the researcher which starts from the initial identification of programme to its final conclusion [7]

1) **Study area** = Kasegaon, 16 Kms from karad, Satara, Maharashtra. A rural area adopted under Rural Health Training Centre (RHTC). Situated on the NH 4.
2) **Study Period** = Study was conducted during the period between May 2013 to June 2013
3) **Design of the Subject** = Community based cross sectional study. To study the quality of life in geriatric population in rural area.
4) **Study population** = All persons of age 60 years and above from rural area for residing at least for last six months.
5) **Study subject** = All persons of age 60 and above from the study area via rural area residing at least for six months.
6) **Study material** = Pretested proforma with pilot study containing details of health checkups, Quality of life questionnaire (tools for measurement of HR-QoL) and socio-demographic factors and clinical materials like Sphygmomanometer, stethoscope, torch, spring dial weight machine, measuring tape, hammer, " Which were standardized in the beginning and regularly during a steady period.

Project was carried out by using assessment of quality of life (AQoL) instrument (Australian Centre for quality of life) with due written consent, comprising 5 – dimension of total 15 – items to assess the health related quality of life (HR-

QoL). The dimensions were illness, independence, relationship, census and mental. Each dimension consists of 4 items.

1) Data coding = It is data coded accordingly.
2) Categorization of total score of HR-QoL

Total score range from 0-45. The categorization was done as follows

15-24 = Best Quality of life
25-33 = Good Quality of life
34-42 = Average Quality of life
43-51 = Bad Quality of life
52-60 = Worst Quality of life

3. Data Collection & Analysis

Initial visits were paid to explain the nature of study in the group of study subjects. By house to house visits interviews were taken as per the proforma and conducted along with examination. The interview was taken in the local language without changing the meaning of the questionnaire in maximum privacy and confidentiality.

4. Results

Table 1: Gender difference in different age groups

	Male	Female	Total
60-64	11	27	38
65-69	13	11	24
70-74	9	12	21
75-79	7	3	10
>=80	1	6	7

In this distribution table about 62% aged were from 60-69 yrs age group i.e. young old in rural area. While only 7% are from 80+ age group. The above table shows significant difference in the age distribution in the rural area.

The distribution of sex in rural area showed that out of 59% of females 38% were from the age group 60-69 and only 6% were from age group 80+ Which was higher compared to Male study subjects (41%) distributed as 24% in age group 60-69 and 1% in age group 80+.

Table 2: Type of family

Type of Family	Total
Nuclear	16
Joint	56
Extended	28

The above table signifies that Majority of the population belong to joint family (56%) followed by extended family (28%) and the last type being nuclear (16%)

Table 3: Socio economic status according to modified BJ Prasad classification:

Socio Economic Class	No. of Individual
Class I	4
Class II	3
Class III	21
Class IV	41
Class V	31
Total	100

The above table signifies a great difference between the socio economic statuses in study subjects. That is Class IV and Class V being 72% showing a high variation in Class I and Class II being just 7%.

Table 4: Addictions

Group	Nil	Tobacco	Alcohol	Both
Male	7	32	10	8
Female	14	43	0	0
Total	21	75	10	8

As mentioned above 75% of people are addicted to tobacco, of which majority being female population (43%) and minority being male (32%). It was observed that 8% were addicted to both alcohol and tobacco, 10% were addicted to alcohol, 21% were not addicted to any.

Table 5: Body Mass

Group	Underweight	Normal	Pre Obese	Obese
Male	4	24	8	5
Female	6	31	17	5
Total	10	55	25	10

As mentioned in the above table 55% of the population lie under the normal range of BMI, of which females is 31% and males is 24%. And about 25% of the populations are Pre obese of which the female (17%) is higher than the males (8%). The underweight (10%) and obese (10%) population being equally distributed in the population.

Table 6: Morbidity Status

Morbidity	No. of Individual affected
Cataract	61
Osteoarthritis	29
Hypertension	23
Diabetes Mellitus	10
Bronchial Asthma	51
Deviated Nasal Septum	14
Sinusitis	8
Chronic Obstructive Pulmonary Disease	9
Others	44
Total no of subjects	100

As per the above table the total no of subjects being 100 out which many individuals were found to be affected with more than one disease. Out of which the disease most commonly seen was cataract (61) followed by Bronchial Asthma (51), Osteoarthritis (29), Hypertension(23), Deviated nasal septum(14), Diabetes mellitus(10), Respiratory disease(9), Sinusitis (8) and other diseases (44) which includes

Table 7: HR-QoL Scoring

HR-QoL (Score)	Scores of individual
Best (15-24)	52
Good (25-33)	39
Average (34-42)	7
Bad (43-51)	2
Worst (52-60)	0

As per the above table the best quality of life is seen in majority of people that is 52% and secondly having good quality of life (39%) and average and bad quality of life being 7% & 2% respectively. And no worst quality of life was observed.

5. Discussion

Majority of the population as depicted in table -1 was in age group 60-69 years, i.e. young old(62%), which was similar to the study conducted by Sengupta et. al. [10] had 60% respondent from the same age group. Another study conducted by Lena et. al. [11] in rural area of Udapi taluka, Karnataka. Which was higher (72.3%) than this study. Female study subjects (61.2%) was higher than the male study subjects (38.8%). In another study conducted by Barua et. al. [12] had 40% male and 60% female (7.7%) were higher than the male. Similar finding was seen in Lena et. al. [15], Joshi et. al[13]., Bansod et. al[14]., Munshi et. al[19]., Swami et. al. [2]and Pratibha and Angadi et. al[13]study. Similar finding was seen study conducted by Shinde, M. B., & Durgawale, P. M. [8]

In rural area the no. of males as a head of the family was significantly higher than the females. (p<0.0001)

Majority of the subject belong to joint family (56%) as shown in the table 2. About 16 % of the families from the rural area are nuclear type. Extended families (28%) in the rural area are more than the nuclear family. In Lena et. al[15] study a joint family study system was seen to be most common (56.8%) among the population interviewed followed by nuclear families (33%) in which the former is similar to the present study but not the later in the rural area. In another study conducted by Rahman et. al[15]. in rural area of bangladesh and B.S. Garg et. al[16] found most of the elderly were living in the joint family which supports the present study.

As despicted in the table 3, in the rural area, the socio-economic class IV was seen in majority (41%), followed by class V (31%) and class III (21%), and least being class I (4%) and class II (3%).

It was observed from the table 4 that 75% of the people are having tobacco addiction, which was much higher than the study conducted by Leena et. al. wich shows 28% in the urban area. Another study by G.V. Niranjan[18] showed female 68.3% and males 42.65% were addicted to tobacco which was slightly more compared to present study being female 57.3% and males 42.7%.

The present case study for different chronic diseases was taken as "known or diagnosed by specialist and taking treatment." According to table no. 6, in rural area, cataract (61%) was most common among the aged. This may be due to long term exposure to sunlight and dusty environment as most of them are farmers. Present study showed prevalence of Bronchial Asthma (51%) of the subject in rural area, which was very high according to the study by Prakash et. al. [23] in urban area which showed (14%). About 14% of the population showed Deviated Nasal Septum of which 8% were affected with sinusitis.

In the study subjects about 29% were suffering from Osteoartritis in the rural population. Which was lower when compared to the study by Lena et. al[12].and Bhatia et. al[17]being 43.7% and 45.7% respectively.

According to the study by Ingle et. al[22]in rural area of pondichery showed Diabetes Mellitus (8%) which supported the present study and Hypertension (14%) which was lower than the present (23%). A study by Lena et. al[15], Dharmvir et. al[20]and Chandwanin et. al. [21], prevealance of Diabetes Mellitus and Hypertension was found as a leading problem which was similar to this study

6. Conclusion

Ageing is a universal phenomenon, with advanced fertility control, improvement in the health and social service, life expectancy has increased. Ageing has profound effect on individual status in the family, the work force, goals and organization of health, social service, policies and practices of the government.

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Paper ID: OCT14263

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