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RESEARCH ARTICLE

ASSESSMENT OF QUALITY OF LIFE OF ELDERLY POPULATION RESIDING IN URBAN AND URBAN SLUM AREA: A COMPARATIVE STUDY

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ABSTRACT

Introduction: Ageing and urbanization are closely related. There are many possible ways in which the urban environment may influence the health and well-being of older residents. Indeed, older people may be particularly vulnerable to the influence of urban characteristics many aspects of urban living that affect the quality of life of older persons go beyond municipal boundaries.
Objectives: 1. To assess and compare the quality of life of the study groups. 2. To suggest appropriate measures for promotion of health of elderly in urban & urban slum area.
Material and Methods: A house to house interview was conducted among all randomly selected urban and urban slum area persons of age 60 yrs and above residing at least last six months with Pretested proform a containing details of health check-ups, Assessment Quality of Life Questionnaire (a tool for measurement of HR-QoL) and socio-demographic factors and standardized clinical materials.
Observations: Total 153 from urban & 135 from urban slum were enrolled for the study. There was significant difference found in the ranking HR-QoL with sex, marital status and type of family distribution in both the areas.
Conclusion: Ageing has profound effect on the individual status in the family, the work force, goals and organization of health, social services, policies and practices of the government. Age, gender, marital status, type of family and relationship dimension affects the Quality of life of elderly. Health is vital to maintain well being and Quality of Life of Aged population.

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INTRODUCTION

Biologically: Aging begins at least as early as puberty and is continuous process throughout adult life,
Socially: The characteristics of members of society who are perceived as being old vary with cultural setting and form generation to generation,
Chronologically: In 1980 UN defined it as age above 60 yrs as old and
Economically: They defined in the terms of retirement from the work force, especially in societies with a normal or statutory retirement age (World Health Organization, 1989).

The Indian aged population is currently the second largest in the world. The absolute number of the above 60 yrs population in India will increase from 76 million in 2001 to 137 million by 2021 (Dr Indira Jai Prakash, 1999).

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The life expectancy increased up to 67.07 years of total population, 65.21 years for male and 69.05 years for females by year 2011 (World Demographics Profile, 2012). Majority of the problems that confront older persons are the result of priorities, policies and practices of society. Ageing is mainly associated with social isolation, poverty, apparent reduction in family support, inadequate housing, impairment of cognitive functioning, mental illness, widowhood, loss, bereavement, limited options for living arrangement and dependency towards end of life (*Mospi.nic.in/mospi_new/upload/elderly_in_india.pd*). All these problems have an impact on the quality of life in old age and health care at the time of need. However, with industrialization and urbanization, disintegration of traditional joint family has been the major social problem. It is thus necessary to strengthen the traditional family system through community education and social intervention (Siva Murthy and Wadakannavar, 2001). There are many possible ways in which the urban environment may influence the health and well-being of older residents (John Beard *et al*., 2012).

1. When considering health in later life, some people think mainly about how long they expect to live. Scientists and health workers too have sometimes focused solely on how to extend life expectancy. However, when working out how to help people live longer, it is also important to concentrate on helping them to live better (www.wpro.who.int). To calculate QoL (Quality of Life) require a scientific and approved tool as it is a subjective phenomenon. Such studies conducted in urban and urban slum area are very rare. So this study was conducted to see the difference in QoL among elderly population in urban and urban slum area and to study the causative factors.

Objectives

- To assess and compare the quality of life of the study groups.
- To suggest appropriate measures for promotion of health of elderly in urban & urban slum area.

MATERIALS AND METHODS

Community based cross-sectional study was conducted in Urban and urban slum area of Karad town, Dist. Satara, Maharashtra. The urban slum area is a slum community adopted under the Urban Health Training Center (UHTC) of KIMS Karad, situated on National Highway -4 (Pune - Bangalore). There are fifteen residential areas present in the Karad town, out of which Somwar peth was selected randomly by using lottery method. All individuals 60 years and above were taken as study subjects from this residential area. Institutional Ethical Committee clearance was taken before the start of the study. By house to house visits interviews were taken as per pretested proforma (which was translated into vernacular language) conducted along with examination. The interview was taken in the local language without changing the meaning of the questionnaire in a maximum privacy and confidentiality.

The Project was carried out by using the Assessment of Quality of Life (AQoL) instrument (Australian Centre for Quality of Life) (www.aqol.com) with due written consent, comprising 5-dimensions of total 15-items to assess the Health Related Quality Of Life (HR-QoL). The dimensions were illness, independence, relationship, senses and mental. Each dimension consists of three –items.

Data coding in general

When entering data from the AQoL into a computer database, the data entry was done according to the rank order and responses were entered as follows:

- 'A' = '1'
- 'B' = '2'
- 'C' = '3'
- 'D' = '4'

i.e. the higher the numerical score, the poorer the respondent's HRQoL.

For data analyses, item responses should be recorded as follows:

- '1' = '0'; i.e. if the first response is selected, the respondent's status is 'normal' and there is no loss of HRQoL.
- '2' = '1', '3' = '2' and '4' = '3'.

This coding will produce scores for each dimension ranging from '0−9', where '0' represents 'normal' or 'good' HRQoL and '9' the worst possible HRQoL for the dimension of interest.[21] The total score ranges from 0-45.

Observations

Socio-demographic profile

About 69.6% and 60.1% aged were from 60-69 yrs age group i.e. young old in urban slum and urban area respectively; while only 3% from urban slum and 14.4% from urban area were from 80+ age group. The proportion of elderly found in urban area was 10.1% and in urban slum area was 7.9%.

Table 1. Rank-wise distribution table of HR-QoL Score in urban and urban slum area

HR-QoL(Score)	Urban(%)	slum(%)	Total(%)
1.Best(0-9)	59 (38.6)	82 (60.7)	141(48.96)
2.Good(10-18)	56 (36.6)	40 (29.6)	96 (33.33)
3. Average(19-27)	33 (21.6)	4 (3)	37 (12.85)
4. Bad(28-36)	4 (2.6)	8 (5.9)	12 (4.17)
5. Worst(37-45)	1 (0.7)	1(0.7)	2 (0.69)

X^2: 29.472, df: 4, P< 0.0001.

About 48.96% people were from first ranking in HR-QOL, while 38.6% and 60.7% were from first ranking as best HR-QoL in urban and urban slum area. 5.9% aged from urban slum and 2.6 % from urban area were in forth ranking i.e. bad HR-QoL.21.6% subjects were from urban and only 3% from slum area in third ranking of average HR-QoL. Only single subject from both the areas having worst HR-QoL. The table shows significant difference in the scorers of both areas.

In urban slum area 77.35% males and half of the females were in first rank, while half of the males from urban respondents and 27.27% females were in same rank. About 8.53%females from 4th rank i.e. bad HR-QoL which were higher than male respondents (1.8%) in urban slum area. This table shows significant difference in HRQOL and sex distribution in urban slum area and Urban area. In urban area majority of the respondents (53.33%) were in first rank from three generation family and 8.69% were in the 4th rank from nuclear family. About 66.6% in urban slum respondents were in first rank while 11.62% were living in nuclear family having bad HR-QoL. Maximum number of urban slum respondents was from joint family in first rank i.e. good relationship dimension.

The above table was statistically significant in urban and urban slum area in relationship dimension and family distribution. Aged living with spouse were higher in first rank in both the areas (urban=47.22%, urban slum=72.85%), while 8.62% were in urban slum having bad HR-QoL. In the above tables HRQOL and Marital status differ significantly in both Urban (p=0.018) and slum areas (p<0.01).

Table 2. Rank-wise distribution of HR-QoL and sex in Urban and urban slum area

Gender distribution				
	Urban		Urban slum	
HR-QOL	Male (%)	Female (%)	Male (%)	Female (%)
1 Best	38(50)	21(27.27)	41(77.35)	41(50)
2 Good	25(32.89)	31(40.25)	9(16.98)	31(37.8)
3 Average	10(13.15)	23(29.87)	2(3.77)	2(2.43)
4 Bad	3(3.94)	1(1.29)	1(1.88)	7(8.53)
5 Worst	0	1(1.29)	0	1(1.21)
	X^2=11.920,P=0.018*,df=4		X^2=12.656, P=0.013*,df=4	

Family distribution						
HR-QOL	Urban			Urban slum		
	Joint	Nuclear	Three Gen	Joint	Nuclear	Three Gen
1 Best	27(35.06)	16(34.78)	16(53.33)	56(66.66)	23(53.48)	3(37.5)
2 Good	34(44.15)	13(28.26)	9(30)	23(27.38)	13(30.23)	4(50)
3 Average	15(19.48)	13(28.26)	5(16.66)	3(3.57)	1(2.32)	0
4 Bad	0	4(8.69)	0	2(2.38)	5(11.62)	1
5 Worst	1(1.29)	0	0	0	1(2.32)	0
	X^2=7.381, P=0.25,df=8			X^2=10.173,P=0.039*,df=8		

Marital status				
HR-QOL	Urban		Urban slum	
	Married(%)	Widow-er(%)	Married(%)	Widow-er(%)
1.Best	51(47.22%)	8(17.77%)	51(72.8%)	29(50%)
2 Good	38(35.18)	18(40)	15(21.42)	23(39.65)
3 Average	15(13.88)	18(40)	3(4.28)	1(1.72)
4 Bad	4(3.7)	*0*	1(1.42)	5(8.62)
5 Worst	0	1(2.22)	0	0
	X^2=19.213, P = 0.0002*,df=3		X^2=10.367,P=0.0157*,df=3	

Relationship dimention						
Relationship dimension (Score)	Urban			urban slum		
	Joint	Nuclear	Three Gen	Joint	Nuclear	Three Gen
1 Good(0-3)	54(70.12)	25(54.34)	26(86.66)	76(90.5)	28(65.1)	6(75)
2 Average(4-6)	20(25.97)	7(15.21)	4(13.33)	4(4.8)	6(14)	2(25)
3 Bad(7-9)	3(3.89)	14(30.43)	0	4(4.8)	9(25)	0
Total	77	46	30	84	43	8
	X^2=27.743, P= 0.01*,df=4			X^2=16.015,P = 0.003*,df=4		

DISCUSSION

The proportion of elderly found in urban area was 10.1% and in urban slum area was 7.9%, which was found higher in urban area and lower in urban slum area compared with recent statistics in NSSO survey 2007-08 [4](India:7.5%, Maharashtra:8.7%).

Quality of Life

About (Table 1) 48.96% of all study subjects in both the groups were having Best HR-QoL (Health Related Quality of Life) (rank 1st), out of which 60.7% and 38.6% in urban slum and urban area respectively. The table shows significant difference in the scorers of both areas (p<0.0001). This suggests that the Quality of life among urban population was lower than that of the slum population. This is in contrast to notion that urban people have good quality of life which may be due to cumulative scored effect of various dimensions (viz. illness, independence, relationship, senses, mental. As most of the study subjects were migrated to slum from rural area, the aged population from urban slum was were less concern about their health and living conditions, while in urban area people were more aware of disease conditions and have high expectations in having good living conditions and from society.

So these conditions may affect the Quality of life among both the study areas. As mentioned in Table 2, there was significant difference found in HRQoL rank-wise and gender-wise distribution in urban area (p=0.013) and in urban slum area (p=0.018).Similarly in Mudey *et al*. (2011) study the association between environmental domain and gender was found to be statistically significant (P< 0.001) amongst the rural population. But in the another study by Barua -Mangesh *et al*. **(**2005**)** showed no significant difference in the mean scores of physical, psychological , social and environmental domains, and also on total scores among men and women. In relationship dimension (Table 2) both areas showed statistically significant difference (Urban area p< 0.01, Urban slum area p=0.0015). As per the current and above studies family plays important role in emotional, physical, and economical support which may affect the Quality of life of aged study subjects

In this study, level of HRQoL and Marital status as showed in table no.2 differ significantly in both urban (p=0.018) and slum areas (p<0.01). Similarly in Barua *et al*. **(**2007**)** study it was observed that the mean scores of the two groups of single and married (living with spouse) differed significantly in the domains of environmental and social relations. This difference between the two groups was also found to be statistically significant for the total mean score of all the domains.

Thus, the overall well-being was significantly affected for those who were single (unmarried) and widowed. Physical safety and security, home environment, financial resources, availability of family members and social care plays important role in Quality of life. In case of widows and widowers all these factors were lacking due to loss of spouse and may affect the Quality of life.

Conclusion

Ageing has profound effect on the individual status in the family, the work force, goals and organization of health, social services, policies and practices of the government. Age, gender, marital status, type of family and relationship affects the Quality of life of elderly. Health is vital to maintain well being and Quality of Life of Aged population.

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