

# A Comparative Study Of Quality Of Life Of Elderly Women Living In Rural And Urban Areas Of Kamrup, Assam

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DOI: 10.47750/pnr.2022.13.S05.413

## Abstract

**Background:** Aging is an experience that is unique to each individual due to their unique personalities, social support networks, and cultural backgrounds. The quality of life (QOL) of older women is significantly influenced by their prior lifestyle, culture, education, health care beliefs, familial strengths, and community integration.

**Objectives:** The purpose of this study was to examine and compare the quality of life and depression of older women living in rural and urban Kamrup districts using the WHOQOL-OLD questionnaire and the Geriatric Depression Scale.

**Methods:** A cross-sectional study of elderly women over the age of 60 was done. After obtaining written consent and matching for age, gender, and socioeconomic position, 60 elderly residents of rural areas and 60 elderly residents of urban areas were randomly selected. The WHOQOL-OLD standard questionnaire and the GDS were used to assess the elderly's quality of life and depression.

**Result:** The elderly's QOL in the categories of autonomy, past, present, and future activities, social participation, and intimacy were significantly higher in a family setting (60.62, 70.62, 66.14, and 58.43, respectively) than in a rural setting (51.35, 62.91, 59.47, and 41.16, respectively) ( $p < 0.05$ ). There was a statistically significant difference between the groups' mean geriatric depression ratings (3.96 within urban and 5.76 in rural elderly women).

**Conclusion:** Quality of life of elderly women in urban areas was better as compared to elderly women in rural areas.

**Keywords:** Rural, Urban, Quality of Life, WHOQOL- old, Elderly Women

## INTRODUCTION

India has the world's second-largest population of people aged 60 and up. [1] As life expectancy has increased, India's elderly population has grown from 20 million in 1951 to 100 million (8.3%) in 2014, with the figure expected to reach to above 130 million by 2021. [2] With urbanisation, modernity, the breakdown of joint family structures into nuclear ones, and the changing role of women, India's traditional definition of family, which was to provide assistance to the old, is rapidly changing. As a result, the elderly have become more vulnerable. Their vulnerability stems primarily from a lack of work, financial hardship, poor health, and societal neglect. [3] To make matters worse, 45 percent of elderly Indians suffer from chronic ailments and disabilities. [4] The quality of life of older women is influenced significantly by their past lifestyle, culture, education, health-care attitudes, family strengths, and community integration. [5] Involvement of older individuals in the development, sponsorship, and evaluation of programmes and services in institutional, outpatient, and community settings improves their quality of life significantly.

Physical and psychological health, living arrangements and level of independence, personal and social relationships, employment capacity, access to health and social care, home environment, transportation facilities, and the ability to learn new skills all influence the older woman's quality of life. [6] There is a paucity of research on the quality of life of older women in rural and urban settings, and this study tried to fill that gap.

## OBJECTIVES

- To assess the health status, morbidity pattern, and living conditions of elderly women living in Rural and urban areas of Kamrup, Assam
- To compare quality of life (QOL) of elderly people living in rural and urban areas, by using the World Health Organization QOL assessment Quality of Life Assessment OLD (WHOQOL-OLD) questionnaire.
- To assess the prevalence of depression in both the groups using the geriatric depression scale (GDS) 15 Short Form.

## MATERIALS AND METHODS

After receiving approval from the Institutional Ethics Committee, a cross-sectional descriptive study on elderly women living in two different settings was conducted from January to July 2020: Those who live in rural areas and those who live in Kamrup, Assam's urban areas. Palashbari, Kukurmara, Changsari, BaihataChariali, Raumari, Chaigaon, and other rural areas were included. Uzanbar, Dhigolipukhuri, Shantipur, Bharalumukh, Kumarpara, Chatribari, Fatasil Ambari, Machkowa, Fancy Bazar, Ulubari, Hatigaon, Bhetapara, Dispur, Ganeshguri, Beltola, Panjabari, Six-mile, Chandmari, Bamunimaidan, Chenikuthi, Kharghuli, Jyotinagar, and Narang Thus, a total of 120 consenting elderly women were picked at random from the region surrounding the specified areas by door-to-door visits and were roughly matched for age, sex, and socioeconomic status. Matching was done to verify that both groups were identical, so removing sociodemographic confounding factors that could affect QOL. The study recruited elderly ladies between the ages of 60 and 90 who were willing to participate. The study excluded elderly women who were bedridden, extremely ill, audio-visually disabled, or cognitively deficient. After discussing the study's goals and objectives to the participants, they gave their informed written consent.

**WHOQOL-OLD** The older women's QOL was assessed using the Module standard questionnaire. The WHOQOL-OLD is a descendant of the WHOQOL-100, which was established by the WHOQOL Group. Sensory capacities, autonomy, past, present, and future activities, social involvement, death and dying, and intimacy are among the six categories (24 items) that make up this multidimensional assessment of QOL (4 items per domain). The scale varies from 24 (lowest possible QOL) to 120 (highest possible QOL); the authors specify the scale ranges as 24 (lowest possible QOL) to 120 (highest possible QOL) (highest possible QOL). The response scales are all five-point scales. [7,8,9] To assess sociodemographic variables, morbidity patterns, living conditions in Rural, and attitude toward life, a predesigned and prestructured questionnaire was used. The collected results were compared between the two groups.

Yesavage et al. created and validated the GDS Short Form particularly for evaluating depression in the elderly, and it was used to determine the existence of depression.

[8,9,10] A score of 0–5 is considered normal. A score of more than 5 indicates depression. The research investigator conducted interviews with the elderly in Marathi, a regional language. SPSS 20 was used to examine the information gathered (SPSS company Bangalore, India). For the comparison of two groups, appropriate tests were applied. It was determined that  $P = 0.05$  was statistically significant.

### Result

In rural areas, more than 45 percent of the elderly were beyond the age of 80, and 63.30 percent of the elderly were widowed. In terms of age, sex, and financial dependency, there was no statistically significant difference between the elderly in both groups. In rural areas, around 31.67 percent of senior women said they had experienced spousal violence/verbal abuse, were unhappy with their meals (16.67 percent), and were unable to pursue hobbies (21.67 percent). The overall living conditions of elderly women in rural areas differed from those of elderly women in urban areas ( $P < 0.05$ ). [Table 1].

**Table 1** Sociodemographic profile and living condition of elderly people

Characteristics	Rural	Urban	p
	(n=60) n(%)	(n=60) n (%)	
Age group (years)			
60-69	14(23.3)	13 (21.7)	>0.05
70-79	18 (30.0)	26 (43.3)	
80 and above	28 (46.7)	21 (35.0)	
Education			
Illiterate and primary	5 (8.3)	10 (15.8)	>0.05
Secondary	17 (28.3)	13 (21.7)	
High school	19 (31.7)	12 (20.0)	
Graduation and above	19 (31.7)	25 (42.5)	
Marital status			
Married	8 (13.3)	39 (65.0)	<0.05
Unmarried	12 (20.0)	6 (10.0)	
Divorced/separated	2 (3.3)	0	
widowed	38 (63.4)	15 (25)	
Family type			
Joint	18 (30.0)	27 (45.0)	<0.05
Nuclear	19 (31.7)	5 (8.30)	
Living with spouse	9 (15.0)	20 (33.4)	
Living alone	14 (23.3)	8 (13.3)	
Financial status			
Dependent	17 (28.3)	22 (36.6)	>0.05
Independent	43 (71.7)	38 (63.4)	

The total WHOQOL-old score in elderly women living in rural regions was 59.42, while it was 64.41 in senior women living in urban areas ( $P > 0.05$ ). The elderly living in urban areas had higher WHOQOL domain scores in terms of autonomy, past, present, and future activities, social involvement, and intimacy (60.62, 70.62, 66.14, and 58.43) than those living in rural areas (60.62, 70.62, 66.14, and 58.43). (51.35, 62.91, 59.47, and 41.16). There were statistically significant variations in the mean scores of the two groups [Table 2]. Rural elderly women (5.76) had a substantially higher GDS mean score ( $P 0.001$ ) than urban elderly women (3.96).

**Table 2** Quality of life of elderly assessed by World Health Organization Quality of Life. old module and geriatric depression scale

Domains WHOQOL-old module in	Elderly	n	Mean	SD	p
I: Sensory abilities	Urban	60	75.83	22.468	0.537
	Rural	60	71.97	26.752	
II: Autonomy	Urban	60	60.62	17.352	0.008*
	Rural	60	51.35	20.198	
III: Past, present and future activities	Urban	60	70.62	17.8	0.013*
	Rural	60	62.91	21.92	
IV: Social participation	Urban	60	66.14	14.732	0.039*
	Rural	60	59.47	17.394	
V: Death and dying	Urban	60	54.79	15.601	0.001**
	Rural	60	70.41	20.484	
VI: Intimacy	Urban	60	58.43	21.432	0.001**
	Rural	60	41.16	23.21	
Total transformed scores with 24 items (0-100)	Urban	60	74.41	12.091	0.036*
	Rural	60	59.42	15.608	
Depression by GOS scale	Urban	60	3.96	4.024	0.0001**
	Rural	60	5.76	3.406	

## DISCUSSION

Until now, India's health policies have mostly concentrated on maternity and child health, with very few programmes in place to assist the elderly. There is a need for the government to be more involved in geriatric care.

In this study, elderly women in rural areas had a mean quality of life of 59.42 15.6 while elderly women in urban areas had a mean quality of life of 74.41 12.09. In every domain, urban elderly women had a higher quality of life than rural elderly women.

In all dimensions of QOL ( $P 0.05$ ), except sensory capacities ( $P > 0.05$ ), there was a statistically significant difference between older women in rural and urban locations, according to this study. The urban samples had a higher quality of life. In a research of health-related QOL among elderly in Taiwanese cities, villages, and islands, it was discovered that the urban elderly population had the highest health-related QOL, particularly in terms of physical health. The elderly on distant islands had the highest vitality and mental health ratings, but the elderly in rural areas, particularly rural women, had the lowest health-related QOL. [10] In an Indian study, single and married respondents differed considerably in the realms of environmental and social relations, whereas senior women in various age groups differed significantly in the domains of physical, psychological, and social interactions. [11]

The QOL of terminally ill and bedridden old women, as well as elderly women with significant hearing impairment, could not be examined because they were excluded from the study. Because the research was limited to a single district in Assam, the results could not be generalised.

## CONCLUSION

The findings of this study revealed that the quality of life of elderly women in cities was better than that of elderly women in rural areas. Rural elderly ladies were substantially more depressed than urban elderly women.

According to this study, elderly women in urban regions have a higher quality of life than old women in rural areas. In India, rural areas with few health care facilities have a large number of elderly women. As a result, policies and initiatives aimed at older women should be implemented in rural areas while also considering the requirements of senior women in urban areas. Volunteers, health care professionals, and family members should all receive training in how to care for elderly ladies. Several things can be done to improve the QOL of elderly women, including forming self-help groups in the local area with the help of volunteer organisations or village level workers, establishing multidisciplinary geriatric clinics throughout the country in both public and private health care settings to manage specific age-related problems, and conducting regular health check-ups.

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