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Life quality and daily life activities of elderly people in rural areas, Eskişehir (Turkey)

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ABSTRACT

Certain difficulties in daily life activities appear and quality of life (QoL) begins to deteriorate with old age. This study aimed at determining QoL and activities of daily living (ADL) of elderly people in rural areas of Eskişehir, and at identifying applicable factors in this regard. Cross-sectional study managed to reach 1301 (81.3%) of elderly people. Face-to-face interviews and the WHOQOL-BREF QoL scale and questionnaire were applied to evaluate daily life activities, as well as instrumental activities all of which contained sociodemographic features. WHOQOL-BREF life quality scale comprised of four domains with grades between 0 and 20. Those who received help from others in the execution of these activities were labelled as "dependent", those who received partial aid during the execution of these activities were labelled as "partially dependent", and those who did not receive any help in their daily activities were labelled as "independent" individuals. Average age of 1301 people contacted was 71.52 ± 5.18 (ranging 65–91 years); 675 of them were women (51.9%), 626 were men (48.1%). Three hundred and eighty-seven of these elderly people (29.7%) had no medically diagnosed illnesses, whereas 18 of them (1.4%) were bedridden. With older age, with the exception of social and environmental areas, life quality got even worse in women, widows, illiterates, bedridden and those with medically diagnosed diseases. As women were more dependent on issues such as housework, shopping, traveling, transporting and bathing, men were more dependent on areas such as meal preparation. No distinction between men and women were identified in areas such as dressing, toilet use, urine and bowel continence and eating. As a conclusion, in cases where medically diagnosed diseases were present, quality of life in women that were dependent somehow in daily activities was worse. It was concluded that medicosocial services for the elderly would be prioritized and studies on chronic diseases would be re-evaluated.

1. Introduction

One of the most important developments in the last century was the increase in life expectancy. Factors such as decrease in birth rates and improvement of treatments for chronic diseases have affected the aging of societies, and finally the number of elderly people increased (Lloyd-Sherlock, 2000). Today, elderly people constitute 14.3% of developed countries. According to WHO estimations, elderly people are expected to constitute 30–40% of the society in 2025–2050 (WHO, 1999a). The increase of the elderly population in Turkey is also evident. For example, the ratio of people of 65 years of age or above was 4.3% in 1990, it reached 5.9% in 1998 (Ministry of Health, 1999).

The main objective of the preventive health services offered to the elderly people is to improve their QoL, allowing independent living and preventing the handicaps. The basis of the preventive health services is the identification of risk factors for dependency and the possible reduction of these risk factors. To this end, a comprehensive evaluation is required (Stuck et al., 2002; Samuel, 2002).

Aging causes health- and social problems. This means that elderly people find themselves in a situation, where they have to continue their lives with certain obstacles and problems. As one gets older, some difficulties arise in daily activities and QoL begins to deteriorate. The term "QoL" covers physical health, level of independency, social activities and environmental factors. Moreover, the term is also effected by health condition, care and unattended requirements of elderly people (Fidaner et al., 1999; Chantal and Holtkamp, 2000). Generally, if someone is not capable of meeting his/her own needs such as clothing, self-care and nutrition, he/she is defined as dependent. Thus, if we wish to ensure health, independence and mobility of the elderly subjects, we have to determine the best way to protect the elderly from diseases and handicaps. The best available

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indicators of handicaps are daily activities and mobility (Sonn, 1996). A real measurement of daily activities can provide more useful information than the determination of liberty with regards to precautions to be taken.

This study describes an effort to determine QoL, ADL-related and other factors concerning the elderly people in the rural areas of Eskişehir.

2. Materials and methods

Sectional study was undertaken in Alpu, Sivrihisar district center and Kaymaz sub-district which fall within the research area of Eskişehir Osmangazi University Public Health Department in Faculty of Medicine. Listing the name and address data collected from clinical records, we could contact 1301 of these elderly people, representing 81.3% of the total number of them.

The WHOQOL-BREF form (Turkish version) with sociodemographic features and ADL questionnaire, as well as the instrumental ADL (IADL) items were also applied to elderly people in form of face-to-face interviews at their homes. The WHOQOL-BREF is a QoL scale, developed by the World Health Organization. The four domains applied in this questionnaire cover the following items.

- Domain I. Physical characteristics (ADL, dependence on medicines and medical aids, energy and fatigue, mobility, pain and discomfort, sleep and rest, working capacity).
- Domain II. Psychological aspects (self-image of body and appearance, negative feelings, positive feelings, thinking, learning, memory and concentration).
- Domain III. Social relationships (personal relationships, social support, sexual activity).
- Domain IV. Environmental circumstances (financial resources, freedom, physical safety and security, health and social care: accessibility and quality, home environment opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment, transport).

The scale was evaluated according to the guidelines developed by the WHO. As each domain relates to the QoL within the framework of its own contents, domain scores were calculated separately. Domain scores varied between 0 and 20. Higher scores indicated higher QoL. Eser et al. (1999) validated the Turkish version of the scale, and assured its reliability.

On the other hand, the everyday activities were also examined using the ADL and IADL scales. ADL scale includes self-care behavior such as eating, clothing, bathing, self-care, mobility between the chair and the bed, use of lavatories, intestinal and bladder control, walking and use of stairs; activities one has to do everyday. The IADL scale includes activities such as preparation of food, housework, purchasing medications, accomplish tasks outside, financial management and use of telephones; activities one has to undertake in order to survive as an individual in society (Sonn, 1996). Elderly people who received help from others in the execution of entire ADL and/or IADL functions were classified as dependent. Those who received only partial help from others, were classified as partially dependent and those who received no help were classified as independent from others.

The interviewed elderly people were also asked, if they had any medically diagnosed chronic diseases.

Ethical approval: Procedures in this study were in accordance with the Helsinki Declaration of 1975. The study protocol was approved by the local ethics board.

Table 1
Distribution of the sociodemographic features in the study group

Parameters	%
Number of the pool = 1301	
Sex	
Male	48.1
Female	51.9
Age (years)	
65–69	43.7
70–74	29.7
75–79	16.9
80+	9.7
Marital status	
Married	67.4
Single	–
Widow	32.6
Education status	
Illiterate	33.3
Primary–secondary graduate	66.6
High school +	0.1
Social security	
No	8.9
Yes	91.9
Living the person	
Alone	18.9
With a partner	65.0
With children	15.4
Other	0.7

Data collected were computer evaluated. χ^2 as a statistical test, variance analysis and *t*-test were used, as well.

3. Results

The gender distribution of our study pool was 675 women (51.9%) and 626 men (48.1%), making a total of 1301 people. The average age (±S.D.) was 71.52 ± 5.18 years (range: 65–91 years). Sociodemographic characteristics of this pool are shown in Table 1.

Almost one third, 387 (29.7%) of the elderly people had no medically diagnosed chronic disease, while the three most frequently occurring chronic diseases were identified as hypertension (33.5%), rheumatism-related diseases (26.1%) and diabetes (14.2%). As regards their dependency, only 18 of them (1.4%) were bedridden. The occurrence of medically diagnosed chronic diseases and dependency data are summarized in Table 2.

Sociodemographic distribution of the WHOQOL-BREF scores concerning QoL are shown in Table 3.

In domains I and II the scores as well as QoL parameters were deteriorated with older age. Women had lower average scores in

Table 2
The distribution of the diagnosed chronic diseases and dependency

Parameters	%
Number of the pool = 1301	
Diagnosed chronic disease	29.7
None	33.5
Hypertension	33.5
Rheumatic diseases	14.2
Diabetes	13.2
Coronary disease	9.3
Heart failure	5.3
Cerebro-vascular disease	2.7
Dependent in daily activities	
Outside home independent	77.4
Inside home independent	21.2
Bedridden	1.4