DOI: http://dx.doi.org/10.22267/rus.192102.144

Universidad y Salud
ORIGINAL ARTICLE

Quality of life in elderly adults from Guerrero, Mexico

Calidad de vida en adultos mayores de Guerrero, México

Elvia Peña-Marcial[1]* orcid.org/0000-0003-1232-6000
Lorena Inés Bernal-Mendoza[1] orcid.org/0000-0002-1799-9522
Leticia Reyna-Avila[1] orcid.org/0000-0001-9862-4062
Rodrigo Pérez-Cabañas[1] orcid.org/0000-0002-3417-2308
Derly Asmir Onofre-Ocampo[2] orcid.org/0000-0002-7648-9645
Ingrid Astrid Cruz-Arteaga[2] orcid.org/0000-0002-6009-944X
Dulce Anel Silvestre-Bedolla[2] orcid.org/0000-0002-8540-2759

1. Research Professor of the Advanced Nursing School No. 1, Autonomous University of Guerrero. Chilpacingo, Mexico
2. Nursing Bachelor Intern, Autonomous University of Guerrero. Chilpacingo, Mexico

Received: 22 December 2018 Revised: 5 February 2019 Accepted: 22 April 2019

Peña-Marcial E, Bernal-Mendoza LI, Reyna-Avila L, Pérez-Cabañas R, Onofre-Ocampo DA, Cruz-Arteaga IA, Silvestre-Bedolla DA. Calidad de vida en adultos mayores de Guerrero, México. Univ. Salud. 2019; 21(2):113-118. DOI: http://dx.doi.org/10.22267/rus.192102.144

Resumen

Introducción: La calidad de vida se define como un estado de bienestar físico, social, emocional, espiritual, intelectual y ocupacional que le permite al individuo satisfacer apropiadamente sus necesidades; un grado de adaptación a su propia condición y a su medio, en función de su estado de salud, sus carencias y del soporte que recibe para suplirlas. **Objetivo:** Describir la calidad de vida desde el ámbito social en el que se desarrollan los adultos mayores en el Estado de Guerrero, México. **Materiales y métodos:** Investigación cuantitativa de corte transversal y analítico, la muestra fue probabilística, se incluyeron 75 adultos mayores de 65 años y más, residentes de asilo, casa de día y localidad rural; el criterio de selección aplicado fue la firma previa del consentimiento informado. Se utilizó el Cuestionario sociodemográfico y Cuestionario de Salud SF-36 versión 2 española Health Survey, constituido por preguntas agrupadas con sus respectivos ítems. **Resultados:** El 80% de los adultos mayores encuestados manifestó mala calidad de vida. **Conclusiones:** Los adultos mayores guerrerenses presentan porcentajes altos de problemas físicos, emocionales, y sociales, que dan origen a una mala perspectiva de su salud y vida.

Palabras clave: Calidad de vida; adulto; percepción. (Fuente: DeCS, Bireme).

Abstract

Introduction: Quality of life is defined as a state of social, emotional, spiritual, intellectual and occupational wellbeing. Quality of life allows individuals to properly satisfy their needs and reach a level of adaptation to their own conditions and environments according to their health status, limitations and the support they receive to supplement them. **Objective:** To describe the quality of life of elderly adults in the State of Guerrero-Mexico, taking into account the social context where they live. **Materials and methods:** Quantitative research using a cross-sectional and analytical approach. The sample was probabilistic, with 75 adults older than or equal to 65 years of age, who were residents of asylums, day houses or rural areas. The applied selection criterion was their signature of the informed consent form. We used the sociodemographic questionnaire and the Spanish version 2 of the SF-36 Health Survey questionnaire that contains questions grouped within their respective items. **Results:** 80% of the older adults manifested a poor quality of life. **Conclusions:** Elderly adults from Guerrero displayed high percentages of physical, emotional and social problems, which ultimately lead to poor health and life perspectives.

Key words: Quality of life; adult; perception. (Source: DeCS, Bireme).

***Corresponding author at:**
Elvia Peña-Marcial
e-mail: elviapema@hotmail.com

Introduction

Aging is an ascending process occurring not only in those who reach the age of 60, but also in people who are more than 80 years of age[1]. It is estimated that the elderly population will continue to grow from 900 million in 2015 to 2,000 million in 2050, representing an increase from 12% to 22% of the total human population, respectively[2].

According to the Mexican National Population Council (CONAPO, in Spanish), Mexico City has the highest elderly population where people of advanced age represent 13% of the total population in Mexico. Likewise, other states such as Veracruz, Oaxaca, Morelos, Yucatán, Michoacán, Sinaloa, Zacatecas, San Luis Potosí, Nayarit, Hidalgo, Guerrero, Jalisco and Durango have elderly populations higher than 10%. Nevertheless, estimates show that all Mexican cities will go through a similar progression, some of them experiencing faster aging rates than others. While Mexico City will have a large proportion of elderly adults (20% of its population will be 60 years or older) in 2030, the remaining states will be at a transition stage with proportions of elderly citizens fluctuating from 10.63% to 16.47%[3].

The senior population has grown lately and due to advances in science, medicine, hygiene, nutrition and more favorable lifestyles it is expected to grow even more. However, longevity comes with its own burdens such as the high cost needed to ensure this population has a good quality of life[4]. Diversity in the elderly population is not coincidental since it depends on genetics or on the decisions made by these people during the course of their life as well as on their relationships with the physical and social environments that directly affect their health status and behavior[5].

Quality of life is a subjective term that is associated with personality, well-being and having a satisfying life and it can be assessed using elements like experiences, health status, and the level of social and environmental interactions developed by individuals[6].

Quality of life is defined as a state of physical, social, emotional, spiritual and intellectual wellbeing that facilitates individuals to properly meet their needs[7]. In other words, quality of life is a degree of adaptation to people's own conditions and environments depending on the health status, deficiencies and support that they receive[8].

The World Health Organization (WHS) conceives quality of life as "the perception that individuals have about their place in existence, in the context of the culture and the value system in which they live and in relation to their objectives, expectations, norms and concerns". It is a very wide concept that is influenced complexly by the physical health, psychological state, level of independence, social relationships and the relationships that people have with the essential elements of their surroundings[7].

The quality of life of older adults (OA) is "the resulting interaction between the different characteristics of the human existence (housing, clothing, food, education and human freedom), each one contributing differently to allow an optimal state of well-being that takes into account the process of aging and adaptation of individuals to their changing biological and psychological environments, which occurs individually and differently. This adaptation affects physical health, memory failures, fear, abandonment, death, dependence or disability of people"[6]. The quality of life of the elderly is achieved to the extent that they accomplish recognition from significant social relationships. This stage will be lived as a continuation of a vital process or it will be lived as a phase of functional decline and social isolation[9].

O'Shea argues that "the quality of life of older adults is a satisfactory life, subjective and psychological well-being, personal development and various representations of what constitutes a good life. It is important to investigate and ask the elderly about how they give meaning to their own lives in the cultural context and in the values by which they live by and in relation to their personal life goals"[10].

Older adults tend to feel that they are no longer taken into account by others, such as at the family level where little by little their presence is not so necessary. In addition, the deterioration of

functionality and autonomy limits the accomplishment of their daily activities[7].

A study conducted in Chiclayo, Perú (2009) on the perception of the quality of life related to the health of older adults from that city identified that the social function (SF), mental health (MH) and vitality (VT) dimensions scored 73%, 69%, and 65% in the SF-36 survey, respectively. The dimensions that scored the lowest were general health (GH), physical role (PR) and body pain (BP), with 50%, 61%, and 62% respectively[11].

The study "Quality of life of older adults in Medellin" carried out in 2013 in Colombia, showed that 71% of older adults stated that they were independent to carry out their daily activities. 45.7% of participants displayed depression symptomatology, 33% had risk of anxiety, 28.3% had functional deterioration, and 54.3% showed possible malnutrition. There was a negative association between quality of life and being a woman, having diabetes, and showing high scores in the scales of functional capacity, depression and anxiety[12].

In 2015 in Colombia, the report entitled "Quality of life of older adult, young old, middle old and very old patients institutionalized and non-institutionalized in the city of Pereira" showed that non-institutionalized patients had better quality of life and mental health than the institutionalized ones. However, the institutionalized older adults had an age range between 65 to 85 years while the non-institutionalized had a 55 to 85 years age range, showing a small difference in average and standard deviation[13].

A study about quality of life and coping strategies for problems and diseases in the elderly in Mexico City revealed that 63.9% of them suffer from diseases, mainly a chronic-degenerative type (53.9%). Although the quality of life was significantly different for sick older adults compared to healthy ones, there were no differences for the type of illness, reported problems and level of coping. The most common types of problems were family (33.7%) and behavior-oriented coping style (54.2%)[14].

A 2017 study about loneliness, depression and quality of life in Mexican older adults included 489 older adults aged between 60 and 97 years old. The authors showed the negative perceptions of old age as well as the perception of social and family loneliness, and mainly explained the symptoms of depression and quality of life deterioration. In addition, it was found that at older ages there is a higher risk of depression, which was exacerbated by diseases and the absence of a partner[15].

Currently, societies have a certain denial of aging which translates into individual psychological imbalance and disarrangement. In other words, there is a lack of acceptance of man in his reality as well as collective antagonism towards this important sector of the population[16].

As people get older, social and individual factors related to living standards become a determining aspect for this population group. Therefore, quality of life is described from the social context in which older adults develop in the state of Guerrero, Mexico. For this purpose, the SF-36 survey was used, which assesses aspects of quality of life in adult populations through eight dimensions: physical function, physical role, body pain, general health, vitality, social function, emotional role, and mental health. The information will be used to stimulate discussion and generate public policies for this population group.

Materials and methods

Study design and population

Quantitative, cross-sectional and analytical study conducted in Chilpacingo (Guerrero, Mexico) during the months of April to June, 2018. The populations consisted of 75 older adults of both genders, of which 25 were asylum residents, 25 came from day houses, and 25 did not attend or depend on any of these institutions and were inhabitants of urban areas. Their participation was voluntary with prior signature of an informed consent form.

Instruments

The instruments used were: (i) a questionnaire about sociodemographic data that contained questions about age, gender, marital status, employment, among others; (ii) the SF-36 version 2 health survey[17], comprising questions grouped by specific items that assess physical function (I am: very limited, somewhat limited, not limited), physical role (Yes, No), body pain (none, a little, regular, a lot, very

much), general health (Yes, No), vitality (always, almost always, many times, sometimes, never), social function (none, a little regular, a lot, very much), emotional role (Yes, No), and mental health (always, almost always, many times, sometimes, never). The SF-36 also includes a general concept of changes in the perception of the current health status and during the last year (good, regular, bad/a lot better, same as the last year, worst). The answer to this question describes the transition of the perception with respect to the improvement or deterioration of the health status.

The data collection technique was a 15 minutes long interview applied to all 75 participants.

Statistical analysis

In order to analyze of the obtained information, a database was created in PASW Statistics 21 software, where a descriptive statistical analysis of the characteristics was performed, one variable at a time. This assessment explored the behavior of quality of life using averages, among other values. Likewise, contingency tables were used to compare previously grouped variables. Finally, Tau C, Tau b and X^2 were applied in order to analyze the effect of the independent variable on the dependent variable.

Ethical considerations

This project followed the NOM-012-SSA3-2012 administrative act, which establishes the criteria for the execution of research projects within the human health field. It also adhered to the article 100 of the General Health Law[18] and the ethical principles of the Helsinki's Declaration. The research was explained to the participants and those who decided to join were asked to sign the informed consent form. Prior written authorization of this study was obtained from the representatives of the System for the Integral Development of Family (FID) and its ascribed organisms.

Results

Most of the study participants were women (52%) with an average age of 73 years. 19% of the study population reported to have bad health, whereas regular health was reported by 61% of them. 52% of the participating older adults stated that they had the same health status as the previous year, while 31% felt worse. Finally, 97.3% of participants did not have a good health perspective and felt less resistant to diseases (Table 1).

Regarding the place of residence, most older adults express that they have good mental health (25% from day houses, 25% living on their own, and 23% from asylum). Nevertheless, 1% of older adults who live in their own houses have poor mental health, 3% from day houses have poor mental health, whereas the older adults that report having adequate mental health were 9% (asylum), 5% (day houses) and 4% (living on their own). Through X^2 (10.003) there is no relationship and through Tau C (0.247) the effect is null (Figure 1).

71% of the interviewed OA report that their normal activities have been frequently affected by physical and/or emotional problems. 52% mention that their degree of difficulty to carry out their activities due to physical and/or emotional problems is regular, a lot and very much. Depression was not associated with (X^2 = 5.640) and is not influenced by (Tan C =0.057) physical function.

Table 1. Perception of health status in older adults

	ƒ	%
Perception of current health status compared to the previous year		
Bad	14	19
Regular	46	61
Good	15	20
Perception of current mental health compared to the previous year		
Worst	23	31
Similar to previous year	39	52
Much better	13	17

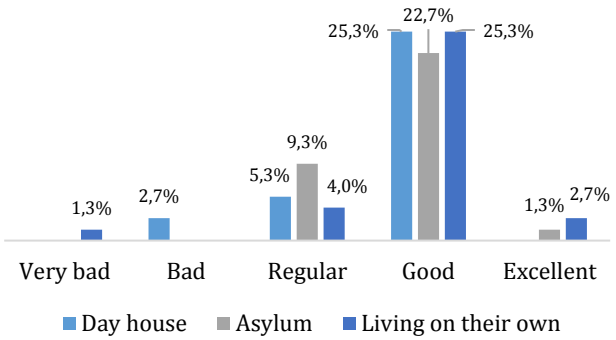

Figure 1. Mental health according to place of residence

Based on the X^2 result (2.232), mental health is not associated with depression. However, the Tau C figure (0.524) indicates a relative association between these two variables (Table 2).

Table 2. Aspects of quality of life

	ƒ	%
Frequency in which their normal activities have been affected by physical health and emotional problems		
Always	16	21.3
Almost always	5	6.7
A lot of times	7	9.3
Sometimes	25	33.3
Never	22	29.3
Degree of difficulty in their social activities caused by physical or emotional problems		
None	23	30.7
A little	13	17.3
Regular	16	21.3
A lot	15	0
Very much	8	10.7
Depression associated with physical function		
Without depression		
It limits me a little	1	1.3
It does not limit me	1	1.3
Moderate depression		
It limits me a little	25	33.3
It limits me very much	4	5.3
It does not limit me	32	42.7
Severe depression		
It limits me a little	6	8
It limits me very much	3	4
It does not limit me	3	4
Mental health and depression status		
Without depression		
Good mental health	2	2.7
Moderate depression		
Very bad	1	1.3
Bad	2	2.7
Regular	11	14.7
Good	44	58.7
Excellent	3	4
Severe depression		
Regular	3	4
Good	9	12

Discussion

In reference to difficulties in the performance of normal daily activities, it was found that 71% of OA have been in this situation because of physical and mental health problems. This figure coincides with the results from a study in Peru, which showed that general health (50%), physical role (61%) and body pain (62%) were the most affected dimensions[11].

A study conducted in 2013 in Colombia revealed that 71% of older adults showed independence to carry out daily activities, 45.7% displayed depression symptomatology, and 28.3% had functional deterioration. There was a negative association between quality of life and being women, high scores in the scales of functional capacity, depression, and anxiety[12].

In 2015, a report in Colombia showed that non-institutionalized participants have a better quality of life and mental health than institutionalized ones. However, institutionalized OA were within a 65-85 years age range, while the other sample presented a range of 55-85 years[13]. These figures are in agreement with those presented in this study, where 19% of OA report having a poor health status and 61% of them mention that it is regular. Most participants consider that they have good health (25% from day houses, 25% living on their own, and 23% from asylums). Nevertheless, some OA think that they have poor mental health. Likewise, there is no relationship and influence between mental health of institutionalized and non-institutionalized participants, but an intermediate association was found between mental health and depression status.

Older adults from Guerrero show higher percentages of physical, emotional and social problems that generate poor health perspectives, compared to studies conducted in Puebla and Jalisco, which present positive health perspectives. These differences are suggested to be caused by economic, social, cultural and educational determinants. Puebla and Jalisco have better public policies that facilitate health care of older adults compared to Guerrero.

Conclusions

Guerrero is one of the poorest states of Mexico, with a notorious lack of programs and public policies to provide a satisfying aging process for the tranquility and fulfillment of the needs of older adults. The quality of life is a priority of public policies of international and national organizations designed to

minimize functional and cognitive deterioration and achieve a healthy aging process.

These demographic changes require a continuous analysis of the needs of the Older Adult so that professionals from different disciplines are able to improve their care and, consequently, their quality of life.

Recommendations

To explore the quality of life from a qualitative point of view, which may facilitate the identification of feelings, emotions and life experiences that older adults go through during the aging process.

In order to understand the sensitivity and human quality in the care of older adults it is important to consider the views of the health care personnel.

Acknowledgments

We thank the approachability, willingness and support of the institutions in charge of the care of this population group. We are grateful to relatives, but most importantly to all participating older adults who allowed us to share unforgettable moments, life experiences and affective connections with them. Learning from them is essential in order to become better people and professionals so we can provide better care to this population.

Conflict of interests

None declared by the authors.

References

1. De los Santos PV, Carmona Valdés SE. Población y Salud en Mesoamérica. Prevalencia de depresión en hombres y mujeres mayores en México y factores de riesgo. Revista Población y Salud en Mesoamérica. 2018; 15 (2):1-23.
2. Organización Mundial de la Salud. 10 datos sobre el envejecimiento. Ginebra: OMS; 2017.
3. González KD. Envejecimiento demográfico en México: análisis comparativo entre las entidades federativas. México: CONAPO; 2015.
4. Falque-Madrid L. La evidencia científica y el arte de envejecer. An Venez Nutr. 2014; 27(1):110-18.
5. Organización Mundial de la Salud. Informe mundial sobre el envejecimiento y la salud Estados Unidos de América. Ginebra: OMS; 2015.
6. Razo-González AM, Díaz-Castillo R, Morales-Rosselñ R, Cerda-Barceló R. Metaanálisis del concepto de calidad de vida en América Latina. Una nueva propuesta: sentido de vida. Revista CONAMED. 2014; 19 (4):149-156.
7. Rubio-Olivares DY, Rivera-Martínez L, Borges-Oquendo L, González-Crespo FV. Calidad de vida en el Adulto Mayor. Varona. 2015;(61):1-7.
8. Rodríguez. P. La atención integral centrada en la persona. Madrid: Fundación Pilares; 2010.
9. Cano-Ramírez CZ, García-Isaac DA, García-Gutiérrez RA, Gloria-Marrufo SY. Vejez generativa: construyendo puentes entre la empresa y el adulto mayor. Vincula Tégica. 2016; 2(1):932-55.
10. Vera M. Significado de la calidad de vida del adulto mayor para sí mismo y para su familia. An Fac Med Lima. 2007; 68 (3):284 -290.
11. Chafio-Prada PM, Gallo-Torres GG. Calidad de vida del Adulto Mayor con Diabetes Mellitus que sea tiende en el Centro De Salud José Olaya Chiclayo – 2015. [Tesis]. Chiclayo: Universidad Señor de Sipán, Facultad de ciencias de la Salud; 2016 Enero 27.
12. Estrada A, Cardona D, Segura AM, Chavarriaga LM, Ordoñez J, Osorio JJ. Calidad de vida de los adultos mayores de Medellín. 2011; 31(4):492-502.
13. Bedoya-Jácome MF. Calidad de vida en adultos mayores, ancianos jóvenes y ancianos maduros institucionalizados y no institucionalizados en la ciudad de Pereira [Tesis]. Pereira: Universidad Católica de Pereira; 2015.
14. Silva Ortiz N. Calidad de vida de los integrantes de la Asociación Adulto Mayor La Tulpuna. Cajamarca, 2016 [Tesis]. Cajamarca: Universidad Nacional de Cajamarca; 2017.
15. Acosta-Quiroz CO, Tánori_Quintana J, García R, Echeverria S, Vales-García JJ, Rubio L. Soledad, depresión y calidad de vida en adultos mayores mexicanos. Psicología y Salud. 2017; 27 (2):179-88.
16. González-Bernal J, de la Fuente-Anuncibay R. Desarrollo humano en la vejez: un envejecimiento optimo desde los cuatro componentes del ser humano. International Journal of Developmental and Educational Psychology. 2014; 7(1):121-129.
17. Institut Municipal d´Investigació Me dica. Cuestionario de Salud SF-36 (versión 2). Barcelona: IMAS; 2003.
18. Secretaria de Salud. NORMA Oficial Mexicana NOM-012-SSA3-2012, Que establece los criterios para la ejecución de proyectos de investigación para la salud en seres humanos. México: DOF; 2013.