Original Article

Assessment On Morbidity Profile And Quality Of Life Among Homemakers At Selected Slums

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DOI: 10.47750/pnr.2022.13.S06.569

Abstract

Amajor component of health is defined as a state of wellbeing in which the individual realizes his or her abilities can cope with the normal stresses of life can work productively and profitably and is able to make a contribution to his or her community. The main aim of this study is to assess the morbidity profile and quality of life among makers at selected slum. **Methodology-**The study design was descriptive non-experimental design. total 60 home makers were selected for data collection. A Non-probability purposive sampling technique was used to collect data from the samples. In order to assess the structured interview schedule and WHOQOL-BREF instrument for quality of life. Reliability was calculated by test-retest method which is found 0.82. **Result-** The major finding showed that the majority of 27(45%) of women were age group from 20-35 years, 27(45%) are primary, 21(35%) having 5001to15000 monthly income, 35 (58.33%) women are Hindu, 24(40%) are living in nuclear family. Most of the home maker's having some kind of morbidity profile. Majority of 34(56.6%) having Average level of quality of life, the remaining 15(25%) having poor level of quality of life, 11(18.33%) having good level of quality of life. The mean of quality of life of homemakers are 64.33±15.48. The correlate the morbidity profile and quality of life among homemakers the value of r is -0.1943 that shows negative correlation. **Conclusion -**There will be a no significant association between the selected demographic variables and the morbidity profile and quality of life among home makers at selected slum areas of Pune. Accept the age of home makers showed significant association between the selected demographic variables and the morbidity profile and quality of life. Thus null hypothesis is rejected and research hypothesis

Key words: Assessment, Morbidity profile, Quality of life , Homemakers.

Introduction

Health is defined more by World Health Organization: ‒a state of complete physical, mental and social well-being and not merely absence of disease or infirmity‖. Health is defined as astate of well-being in which a person recognizes his or her own potential, can cope with daily responsibilities, work successfully and productively, and contribute to his or her community. Mental well-being is a crucial component of health. (Photo courtesy of WHO) Aging is a natural process that impacts everyone, including individuals, families, communities, and societies. It's a natural, gradual, and unstoppable process. "You don't repair old age; you preserve it, promote it, and prolong it," Sir John Sterling Ross said. Preventive medicine is based on these ideas. With the passage of time, ageing is often viewed as a process that weakening in an individual's intentional dimensions as a consequence of organizationalchange so wing to a lack of

finance in the health industry and a growth in the costs of health care Healthy ageing does not have a detrimental impact on health-related quality of life, as seen in several nations, implying that living a decent quality of life for a long time is conceivable. Cultural variations seldom affect the specific extent of quality of life, but they do have an effect on its objective dimension. Currently, there is a rise in the quality of life. Standard of living has risen to the top of policymakers' agendas across the world, particularly among the elderly. Quality of life is a multifaceted and individual term described as "dynamicinterplay between the external circumstances of an Individual's existence and the internal justifications of those situations. [1] Married women in India are multi takers Wife, mother, Daughter, Daughter in law. This is very true, when it comes to a home maker, who acts more like a super human. Indian Patriarchal society expects these women to take care of their families once they are married and most of them quit their jobs. This leaves them with a lot of their aspirations unmet, making them financially dependent and dis empowered.

Need of Study

Warble Priya et al., (2019) conducted a study to analyse the morbidity profile, health seeking behaviors, and home learning survey in the senior population for adaptive measurement. It was cross sectional descriptive study with random sampling method. Tool was collected by interview based closed ended questionnaire as a result 64.1% participants were in the 60–69- year-old age group 94.1 percent of current smokers have 1-3 morbidities.4.1 percent had a morbidity of 4-6. A history of fall was given by 37.3 percent, while a history of fracture was given by 31.4 percent. 13.6 percent of cataract operations are performed. Fracture procedures account for 16.8% of all procedures. 10% of people had dental work done. A total of 78.6% got both allopathic and Ayurvedic care. The majority of the participants sought treatment in government facilities.[4]Already than zines co., (2016) did research on the senior population's health-related living standards and comorbidity. It was cross-sectional research that focused on the senior population in three villages in rural Malaysia. Participants aged 60 and above were chosen forface-to-face interviews derived from the findings of a health-related reliability survey, which indicated a median age of 67.71 years percent. Five co-morbidities were found: hypertension (67%), joint and muscle pain (63%), gastrointestinal discomfort (67%), poor eyesight (58%), and hearing difficulty (33%) This is the relationship between domains and socio-demographic parameters (gender, marital status, association membership) that indicates health and social support for rural residents, such as association membership and health care.[5]

Aim of the Study

The main aim of the study was to assess on morbidity profile and quality of life among homemakers at selected slums

Research methodology

The illness profile and living standards of homemakers in rural regions of Pune are assessed in numerical form in this research, and the data is analyzed using statistical methods. A quantitative research technique will be used in order to attain the study's expected goals. The descriptive research method will be employed to carry out the investigation for this project. It examines the morbidity picture or quality of life of homemakers in Pune's rural districts. variable under study are Independent variable is Morbidity profile and Dependent variable is Quality of life. The location of the research is referred to as the setting. Quantitative researchers make it a point to study their chosen topics.This study was conducted at selected slum areas of Pune. In this study, target population comprises home makers at selected rural areas of PuneA home makers population of selected area is approximately among this population approximately are the home makers with the age group 18-59 years who is home makers A sample, according to Mugenda, is a sample chosen to take part in research. The research used a sample size of 60 homemakers in slums. The samples chosen for data collection in this investigation were those that matched the inclusion criteria both were available throughout the data collection period. Our pas purposive sampling approach was used to choose

them. To choose samples, the selection conditions were used: Inclusion Criteria and Exclusion Criteria .Inclusion Criteria are Home Makers Who are present at the period of data collection?,Who can understand Marathi, or English? Exclusion Criteria are Who are not present at the time of data collection.and Who are not willing to participate in study. The current research aims to determine the morbidity characteristics and living standards of homemakers in selected slums." A review of tool will develop by their searcher snore viewing literature and in consultations with medical and nursing experts in the field of community medicine and nursing. The tool consists of two sections Section-A: Demographic variables like Age, family type, income, education, disease condition .Section B: For quality of life, a structured interview session and the WHOQOL-BREF questionnaire were used. To confirm the content's legitimacy, a tool was supplied to experts on November 28, 2021. were contacted and provided with useful suggestions and feedback on the research instrument. The specialists were from the area of Community Health Nursing. One of them was a Statistician. In this study the reliability of the structured interview session and Questionnaire assessment for quality of life was assessed using ten samples. Samples took an average of 20-30 minutes to score the questions, with a retest after a few minutes. The approach was used to assess reliability, and the co-efficient was computed using ―Karl Pearson's correlation coefficient formula‖. larger than 0.70, the test is considered Credible. The information was gathered via the use of a scheduled interview schedule. A total of 60 samples have been chosen. After the pre-test, the study began. During the pilot research, there were no issues. Overall, it was discovered that this tool may be used to collect data to examine the comorbidity profile and living standards of homemakers in Pune's Slums districts."Based on the study's goals, descriptive analysis statistics will be used to analyses the data. The morbidity picture and livability among homemakers in selected slums regions of Pune will be assessed Descriptive statistics such as mean, median, mode, & standard deviation are used. Inferential statistics will be utilized to determine the relationship between morbidity characteristics and quality of life and chosen demographic factors using Chi-square and t-tests

Result

Section I

Analysis of data related to the Quality of life of home makers at selected Slum.

Table 1: Quality of life of home makers at selected Slum.

n=60

Quality of Life	(f)	(%)
Poor (Score 26-52)	15	25.0
Average (Score 53-78)	34	56.7
Good (Score 79-104)	11	18.3

25% of the homemakers had poor quality of life (Score 26-52), 56.7% of them had average quality of life (score 53-78) and 18.3% of them had good quality of life (score 79-104).

n=60

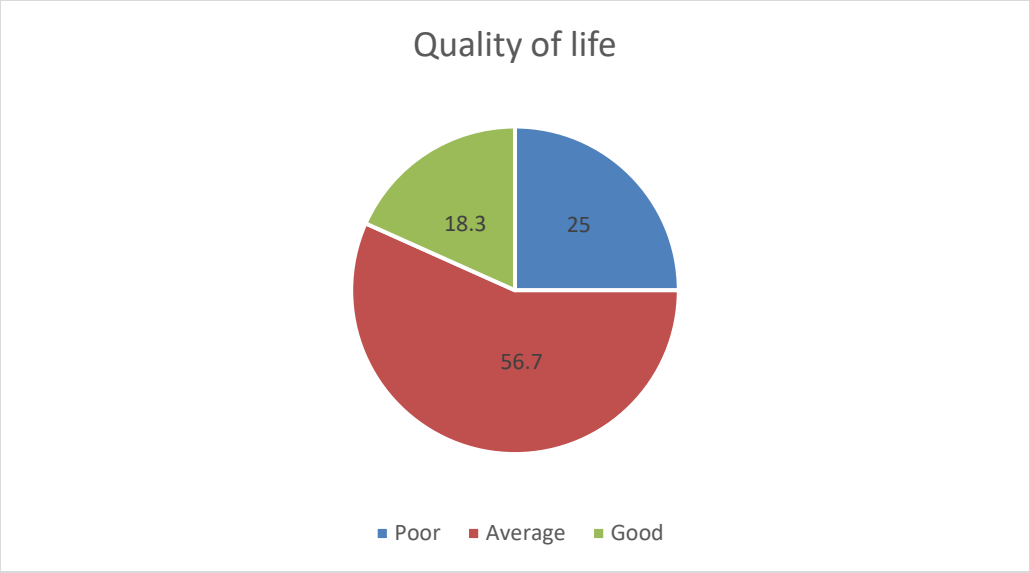

Fig-1 Pie Diagram showing Quality of life of home makers at selected Slum

Section II

Analysis of data related to correlation between the morbidity profile and quality of life among home makers

Table 2:t-test for the significance of Pearson's Correlation coefficient between the morbidity profile and quality of life among home makers

n=60

Statistic	**Value**
r	-0.19
t	1.49
p-value	0.142

Researcher used Pearson's correlation coefficient for the correlation between the morbidity profile and quality of life among home makers.

Analysis of data related to correlation between the morbidity profile and quality of life among home makers.

n=60

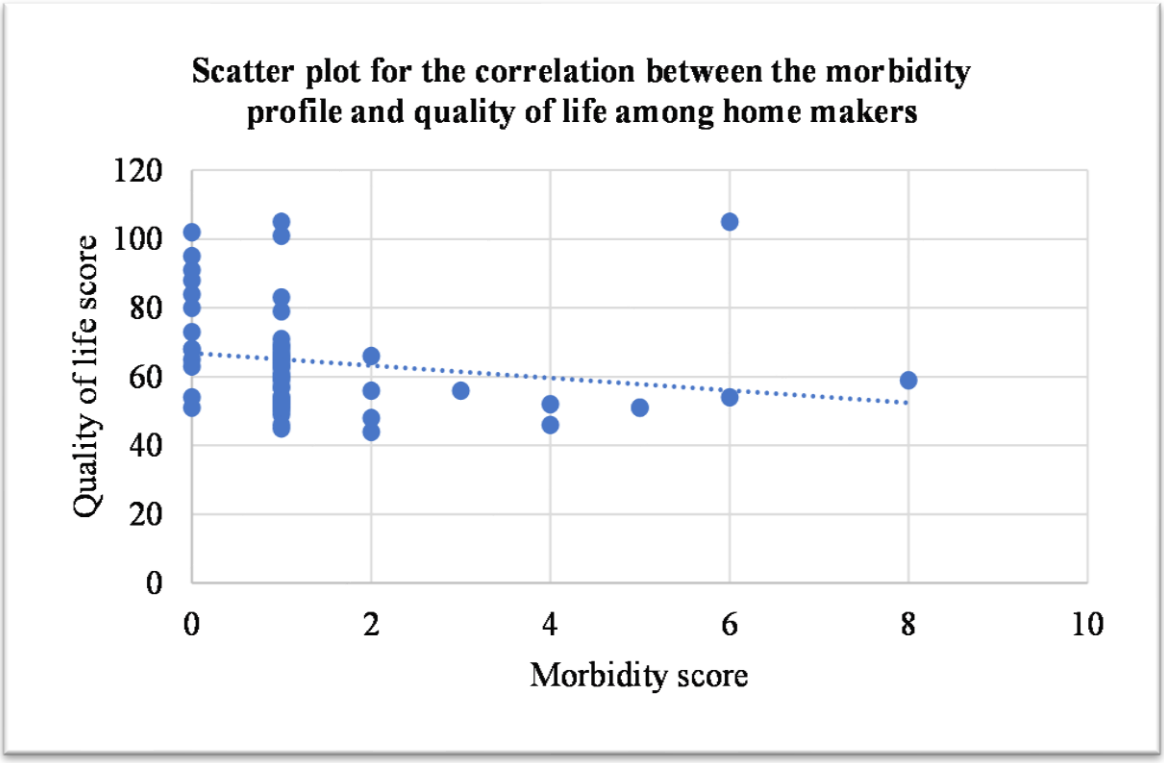

Fig-2 Scatter plot Diagram showing Quality of life of home makers at selected Slum

Discussion

The findings of the study have been discussed with reference to the objectives and hypothesis stated. The study's results were addressed, along with the aims and hypothesis. 70 people from the Konda cherry rural population gathered data. Out of 70 samples, the results indicated that in terms of age 24 (34%) samples fell into the under 40- year-old category, 27 (38%) samples fell into the 40-60-year-old category, and 19 (27%) samples fell into the 60-80-year-old category. In terms of gender, males accounted for 28 percent (40 percent), while females accounted for 42 percent (60 percent). In terms of educational qualifications, 32 (45%) of the 70 people in the sample had no formal schooling. In terms of occupation, 31 (44%) of the 70 samples were jobless, while 32 (45%) were skilled people. In terms of marital status, 37 (52%) of the 70 samples were Married. Regarding economic status out of 70 samples 34 (48%) were middle level. Regarding religion out of 70sample 43 (61%) were Christian. Regarding type of family out of 70 samples 49 (70) were belong to nuclear family. The morbidity profile shows epilepsy 7 (10%), depression 25 (36%), cataract 25 (36%), stye 10 (14%), asthma 14 (20%), tuberculosis 7(10%), whooping cough 15 (21%), hypertension 27 (38%), congenital heart failure 5 (7%), tooth decay 33 (47%), anemia 32 (45%), gastritis 17 (24%), Diarrhea 18(25%), diabetic mellitus 22(31%), thyroid problem 27 (38%), joint pain 22 (31%), osteoporosis 21 (30%), hearing 20 (28%), locomotion 12 (17%), visual impairment11(15%), speech 10(14%), accidents 7 (10%), injuries 4 (6%), poisoning 2 (3%). The quality life shows that the mean score for excellent 12.01, good 52.2, fair 4.97 and poor 2.58.

Conclusion

The relationship between homemakers' morbidity profile and their quality-of-life R has a value of -0.1943, indicating a negative correlation. There would be no statistically significant link between the demographic

factors chosen or the sickness profile and liv ability of homemakers in Pune's slums area. Except for the age of homemakers, there was a strong link between the demographic factors studied and the sickness profile and wellbeing.Thus null hypothesis is rejected and research hypothesis i.e. H1 **:** There will be a significant difference in the morbidity profile and quality of life among home makers at selected rural areas of Pune .and H_2 : There will be a significant association between the selected demographic variables and the morbidity profile and quality of life among home makers at selected rural areas of Pune is accepted.

Conflict of Interest: The authors certify that they have no involvement in any organization or entity with any financial or non-financial interest in the subject matter or materials discussed in this paper.

Funding Source: There is no funding Source for this study

Acknowledgement: I most sincerely convey my deep sense of gratitude to my guide/Organization for her/their remarkable guidance and academic support during this study.

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