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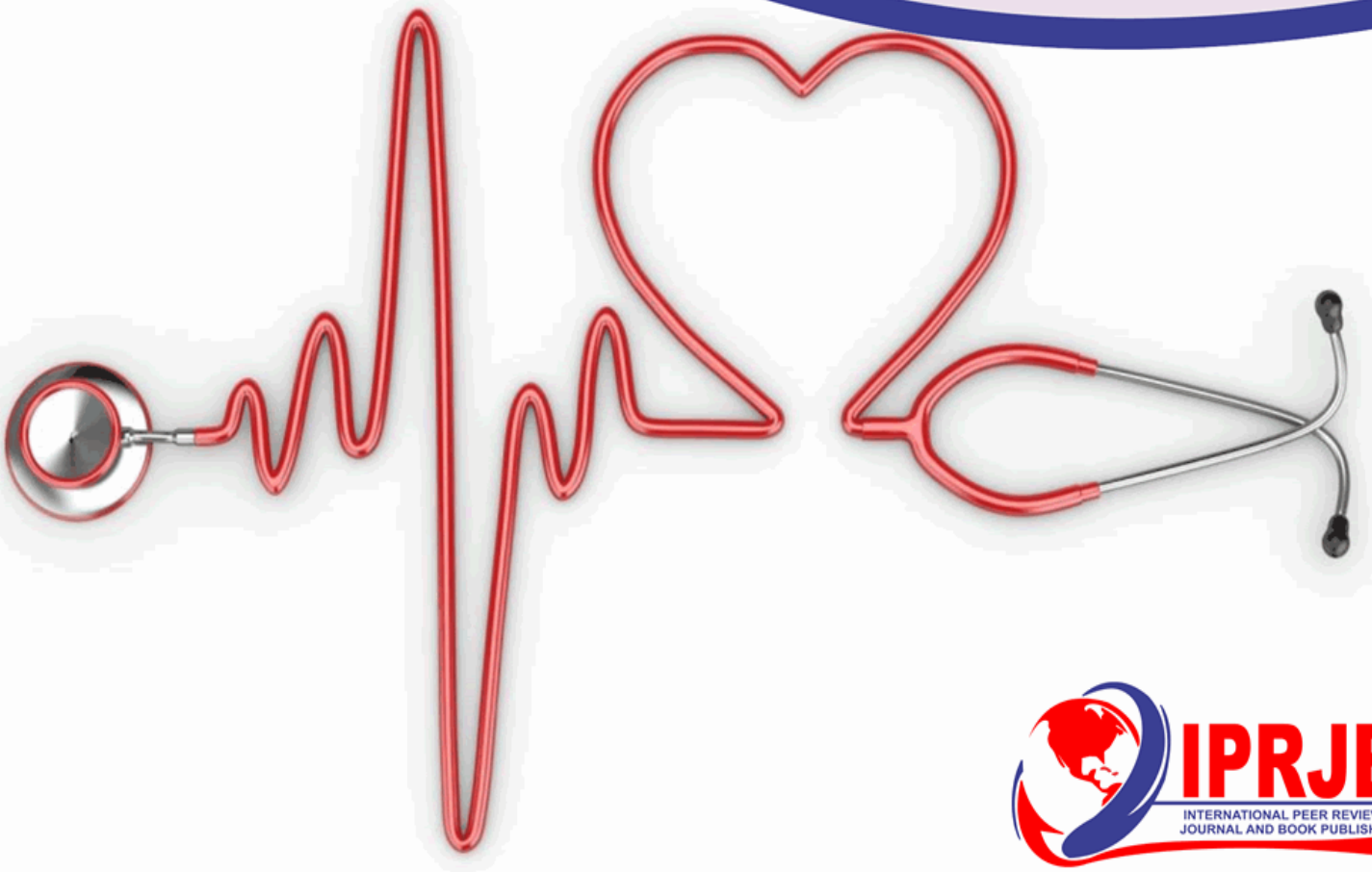
THE ASSOCIATION BETWEEN SOCIAL SUPPORT AND QUALITY OF LIFE AMONG THE ELDERLY PEOPLE WITH CHRONIC ILLNESSES IN THE RURAL COMMUNITY

Faiza A. Abou El-Soud, Esmat El sayed Ibrahim, Ghada Mohammed Abd Elsalam



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THE ASSOCIATION BETWEEN SOCIAL SUPPORT AND QUALITY OF LIFE AMONG THE ELDERLY PEOPLE WITH CHRONIC ILLNESSES IN THE RURAL COMMUNITY

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Abstract

Background: In the recent decade, elderly people who live longer tends to have chronic diseases that interfere negatively with the quality of their lives, that is why those elderly are in need of social support in order to improve their quality of life. Whereas, one of the main goals of Healthy People 2020 is to enhance the high-quality, longer lives by creating physical and social environments that promote good health for all. **Aim**: The present study was aimed to examine the association between social support and quality of life among the elderly people with chronic illnesses in the rural community.

Methodology: A cross-sectional descriptive design was carried out to describe the social support dimensions and quality of life domains, and a correlational design was conducted to examine the association between social support and quality of life among the elderly people with chronic illnesses in the rural community. **Study sample:** A convenience sampling technique was used to recruit 185 elderly persons who are eligible for inclusion criteria to participate in this research. **Research Setting:** The data were collected from May, 2017 to August, 2017. This study was conducted in the rural community during home visits where the study sample of the elderly participants was recruited from their homes in Shebin Al-Kom capital city, Menuofiya Governorate, Egypt. **Tools**: Face to face interview questionnaire was conducted which included four instruments **I.** Socio-demographic characteristics; **II.** Interpersonal Social Support Evaluation List (ISEL); **III.** World Health Organization Quality of Life (WHOQOL); and **IV.** The Charlson Comorbidity Index (CCI).

Results: The result of this study indicates that social support was significantly correlated with age, gender, marital status, levels of education, patterns of living arrangement, and types of family. Meanwhile, there is no statistical significant correlation between social support and severity of the co-morbid condition. Correlation coefficient analysis showed that a positive correlation between social support and quality of life where the older participant group who perceived more social support had better quality of life compared to the elderly group who are not perceived social support. The older adult participants who categorized in the current study as young- old group (60-74 yr.), male, married, highly educated, and who are living with their family, particularly the elderly people who are living within the extended family are more experience to perceived social support which contributing positively to have a better quality of life compared to the elderly people who are not perceived social support. **Conclusion and Recommendations:** Social support is a contributing factor to enhance quality of life among the older adult participants. Therefore, this study recommended that all the health care providers, particularly the nurses to perform a careful investigation of older adults through reviewing of the factors that might be directly affected social support and may have influence on their quality of life. Hence the professional nurse can play an important part in recognizing the elderly adults who may potentially be experiencing loss of social support and need a referral for providing a social support to avoid deterioration of the quality of their lives.

Keywords: *Social Support, Quality of life, Elderly, Chronic Illness*

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1.0 INTRODUCTION

Amongst 2015 and 2030, the number of population aged 60 years or over in the world is proposed to raise by 56 percent, from 901 million to 1.4 billion. Predictions point out that in 2050,the universal population of older adult is anticipated to more than twofold its size in 2015, reaching closely 2.1 billion. Furthermore, globally the number of people aged 80 + years "oldest-old" cohort group, is growing even faster than other older cohort groups that including "young-old and old-old" groups. [1,2] Of those who survive to the age of 85 today, the life expectancy is about 7 more years for women and 6 years for men. Similarly, the number of older persons is predicted to grow fastest in Latin America and the Caribbean with an estimated 71% increase in the population aged 60 years or over, Asia 66 %, Africa 64%, Oceania 47%, Northern America 41% and Europe 23%.[3,4]

Likewise, in Egypt the recent estimation by 2050 that the life expectancy at birth is 70.1 years for males and 72.9 years for females. According to the Egyptian census, the proportion of the older population increased from 6.27% in 2006 to 6.9% in 2015 and it is expected to reach 9.2% in 2021 and 20.8% in 2050. The increase in life expectancy is a result of rising longevity and decreasing fertility, where the average number of children in the eighties were five children per family and a decrease of three children in 2005 and two children in 2017. Therefore, it is expected to have the largest number of the older population (23.3 million) and oldest-old (3.1 million).[5,6]

Several studies proved that the current global demographic trends of older persons can expect to live longer and possibly also have fewer adult children as potential sources of support among old age. In 2015, there were 7 persons in the traditional working ages"20-64 years", for each older person aged 65 years or over in the world, but by 2050, there will be 3.5 working-aged persons for each older person in the world, and all major regions except Africa are expected to have potential support ratios of 3.2 or lower. In response to these current trends in population ageing, many of the elderly population may have unsatisfactory levels of support that have a negative impact on the health and quality of life. [5,6]

Due to expanding the segment of elderly people in the total population is globally, that is why it becomes one of the greatest social alterations and change in the demographic structure of the 21st century, which have deleterious implication on all sectors of society, including health, labor, financial and social affairs as well as patterns of older adult interaction with their family, close friends, neighbors, coworker and community resources. [1,3]

According to Bélanger et al.,(2016); White, et al., (2009), reported that the social support is a social interactions and networks of relationships that are proposed to provision and strength the well-being of the individual. Hence, social support has been an important social determinant of health that helps individuals, particular elderly age group for reaching the physical, emotional needs, diminishes the effects of stressful events and provides optimistic among elderly that leading to a positive influence on the general health status of the older population.[7,8]

Significance of the problem

Social support as a relevant feature of the quality of life, whereas the quality of life is described as a way that reflect the point of in how the persons perceive themselves able to function physically, emotionally, mentally, and socially. Furthermore, quality of life is estimated of remaining life free of damage, functional limitation, disability, or handicap.[9,10] Thus, the beneficial outcome of social support and social integration on health and survival of elderly are strengthening coping and recovery from illness which means a good social support that lead to positive quality-of-life. On contradictory, lack of social support, social isolation and lack of neighborhood had a negative impact on immune, metabolic, and cardiovascular systems as well as health-related behaviors that mean social isolation and insufficient social support are leading to negative quality-of-life. [7,11] In aprōpos, one of the main goals of Healthy People 2020 is to enhance the quality and lengthen the years of healthy life of older adults. [9] In addition, in all Holy books, including Islam, there is a great value that the elderly must be preserved with definitive respect and a treat to be in a high position among the family members and supported by their families for all their needs. There are several verses in the Quran are stating that Muslims should appreciate and regard the elderly as respected and valuable members of the community (e.g., Verse 23 of Asra Surah, Quran). [10]

Based on the extensive literature reviews which indicate that there are associations between low social support and health-related quality of life. At the same time, there is a lack of researches of the social support and quality of life among the elderly population in Egypt, Menoufiya Governorate. For that reason, this study pursuit to assess the influence of social support on quality of life among elderly with chronic illness.

The Aim of the Study: To examine the association between social support and quality of life among the elderly with chronic illnesses in the rural community.

Research Questions :

Q1. Is there a significant difference in the quality of life among the elderly participants who perceived or not perceived social support?

Q2. Is there a significant association between social support and quality of life among the elderly with chronic illness?

Q3. What are the contributing factors that affecting social support among the elderly with chronic illness?

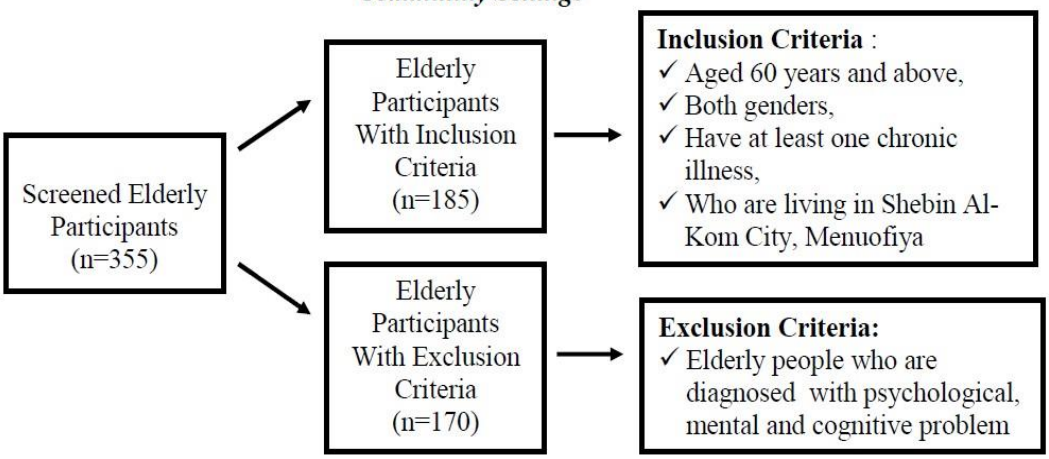
2.0 METHODOLOGY

Research Design: A cross sectional descriptive design was carried out to describe the social support dimensions and quality of life domains, and a correlational design was conducted to examine the association between social support and quality of life among the elderly with chronic illnesses in the rural community.

Research Setting: The data were collected from May,2017 to August,2017. This study was conducted in the rural community during home visits where the study sample of the elderly participants was recruited from their homes in Shebin Al-Kom City, Menuofiya Governorate, Egypt.

Study Sample: The target population was encompassed of the elderly participants who recruited by a convenience sampling technique. The researchers quantified the inclusion and exclusion criteria for participation who registered in the study. In this study, sample size was 185 older adults that calculated by using power analysis (G power) of α 0.05, power 90, medium effect size of 0.2, using the correlation test, considering the confidence level 95%, and confidence interval 5%.[(11)] The study sample was selected as the flow chart described below **(In Figure 1A).**

Figure (1A) - Flowchart of Study Sample Recruitment Procedure from Community Settings



Pilot study: The questionnaire was piloted among 18 elderly people to determine whether the proposed study is feasible, to identify potential problems with the research design, to examine the validity and reliability of the data collection. In addition, the purpose of piloting was to examine the instrument for timing, clarity and accuracy. All the necessary modifications were made accordingly.

Tools of data collection: Face to face interview questionnaire was conducted by the researchers to gain a deeper insight to specific answers by treating the questionnaire like a meaningful discussion and deducing the validity of each response. The answer of the questionnaire was taken 20-25 minutes. This questionnaire is included four tools:

I. Socio-demographic characteristics: It consists of age, gender, marital status, level of education, patterns of living arrangement, and types of family.

II. Interpersonal Social Support Evaluation List (ISEL): It is 40 statements that consist of four social support subscales (SSS) that designed to assess the perceived availability of four separate functions of social support as well as providing an overall support measure. These subscales are included **(1)."Tangible Subscale"** is intended to measure the perceived availability of material aid; **(2). "Appraisal Subscale"** is projected to measure the perceived availability of someone to talk to about one's problems; **(3)."Self-Esteem" Subscale,** is

proposed to measure the perceived availability of a positive comparison when comparing one's self to others; and **(4)."Belonging Subscale,** is intended to measure the perceived availability of people one can do things with. Each subscale is measured by 10 items on a 4-point scale ranging from "definitely True = 3 score" to "Definitely False = 0 scores". The total scores of the ISEL ranged from 0-3, with higher scores indicating that the elderly participants who perceived good social support and lower scores indicating that the elderly participants who not perceived poor social support. The ISEL is a valid and reliable instrument for measuring social support. This instrument is reliable where internal-consistency (Cronbach's alpha: 0.452-0.752) and test-retest reliability (intra-class correlation coefficients (ICC): 0.631-0.847). [12,13]

III. World Health Organization Quality of Life (WHOQOL): The WHOQOL-BREF instrument assesses the individuals' perceptions in the context of their culture and value systems, and their personal goals, standards and concerns. These included four items for each of the 26 facets of quality of life. This instrument measures the following four domains: **(1). Physical Health** that includes (7) items to measure physical state **(2). Psychological Health** that includes (6) items to measure cognitive and affective state **(3). Social Relationship** to measure interpersonal relationship and social role in life; and **(4). Environment** that includes (8) items to measure relationship to salient feature of the environment; and **Overall quality of life** that includes one item relating to the health-related quality of life and one item general quality of life. [14] The respondents rate is given on a 5-point scale ranging from 1 (very poor) to 5 (very good). The total items, scores ranged from 1-5, with higher scores indicating the elderly participants have better QoL and lower score indicating the elderly participants have worse QoL. The reliability of the instrument (WHOQOL) is assessed by means of Cronbach's alpha: Overall WHOQOL Scale (0.93), physical health domain (0.80), psychological health domain (0.77), social relationships domain (0.69), and environment domain (0.83). The validity of the instruments was assessed by means of the convergent, the discriminant and content validity and appears to be valid with sufficient sensitivity. The Arabic translation of the WHOQOL-BREF has impressive reliability and validity indices. The intra-class correlation for the test-retest statistic and the internal consistency values for the full questionnaire and the domains had a Cronbach's alpha ($\geq$0.70). [14]

IV. The Charlson Comorbidity Index (CCI): It is used to assess the severity of the co-morbid condition of the elderly participants. A list of sixteen diseases were categories based on the strength of their association with mortality. In severe conditions, the weighted score of the diseases was given from 2 to 6 scores, while in mild condition, the weighted score was given (1) score. In the current study, the total index score was classified into severe co-morbidity (32-96), moderate (17-31), and mild (1-16). Test-retest reliability was (ICC 0.94; 95% CI 0.72-0.99). [15]

Validity and Reliability: CCI and ISEL tools were tested for reliability and validity. In the current study, these tools were adopted and translated from English to Arabic language by independent translators for the convenience of its contents and tested for content validity by different experts in the field of community health nursing and geriatric nursing. Required modification was done accordingly. This version was checked by the researchers of the present study to assess similarity between the original version and back translated version to avoid discrepancies. The internal consistency was tested after translation CCI tool in Arabic language

where the values of the Cronbach's alpha were (0.91); while the value of the Cronbach's alpha for the ISEL-40 total scores was (0.75), Tangible Support (.76), Belonging Support (.73), Self-esteem Support (.74), and Appraisal Support (.72).

Data analysis: The quantitative data collected in this study were entered and analyzed using Statistical Package for Social Sciences (SPSS) version 20, Chicago, IL, USA. [16] Data were presented using descriptive statistics in the form of frequencies and percentages and means and standard deviations for quantitative variables. Descriptive analysis was used to describe the demographic data and explore the current dimensions of perceptions of social support; examine the degree and domains of quality of life. Inferential statistical analyses were conducted to the Chi-square test was employed to determine the significant difference among groups in relation to the socio-demographic characteristics and social support. The Pearson Correlation Coefficients (r) was used to examine the association between social support and quality of life among elderly participants in the study sample. The statistical test of significance p-value was set at <0.05.

Ethical Considerations: In this study, the data collection commenced after approval was granted by the College of Nursing. All study participants were fully informed regarding the purpose of the study and expectations of participation. Also the researchers were clarified that there are no potential risks associated with their participation and they have the right of withdrawing from the research without penalty. Confidentiality and privacy were maintained on all data collection forms by using codes to identify participants instead of names.

3.0 FINDING

Table 1 - presented descriptive statistics for the social support dimensions. In this table, the full range of scores was observed for all the social support subscales and the Mean (M) and Standard Deviation (SD) for each dimension. A score for each social support subscale was computed by averaging across items to calculate the scale score. Scales were then transformed so that the lowest score was 0 and the highest possible score was 30. In the present study , the mean and standard deviation for: Tangible Support was (M±SD: 19.49±5.07); Belonging Support was (M±SD: 20.92±4.62); Self-esteem Support was (M±SD: 21.41±4.19); Appraisal Support was (M±SD: 20.71±4.46); and Overall Social Support was (M±SD: 45.04 ± 8.52), this indicating the study sample are more needed of different types of support.

Table (1): Descriptive Statistics for Mean Scores of the Social Support Dimensions among the Elderly Participants in the Study Sample

Social Support Dimensions	Items No.	Observed Ranged	Mean ± SD
Tangible Support	10	0-30	19.49± 5.07
Belonging Support	10	0-30	20.92± 4.62
Self-esteem Support	10	0-30	21.41±4.19
Appraisal Support	10	0-30	20.71±4.46
Overall Social Support	40	0-120	45.04 ± 8.52

Table (2) displayed descriptive statistics for the quality of life domains. In this table, there the full range of scores was observed for all the quality of life subscales and the Mean (M) and Standard Deviation (SD) for each domain. A score for each quality of life subscale was computed by averaging across items to calculate the scale score accordingly. The mean and standard deviation for: Physical Health (M±SD:12.31±2.54); Psychological Health (M±SD: 11.58±3.45); Social Relationship (M±SD:5.27±1.11); Environment (M±SD:17.69±4.52); and Overall Quality of Life (M±SD:4.88±0.53), this indicating the study sample have poor quality of life which might improve by providing different types of social support.

Table (2): Descriptive Statistics for Mean Scores of the Quality of Life Domains among the Elderly Participants in the Study Sample

Quality of Life Domains	Items No.	Observed Ranged	Mean ± SD
Physical Health	7	7-35	12.31±2.54
Psychological Health	6	6-30	11.58±3.45
Social Relationships	3	3-15	5.27±1.11
Environment	8	8-40	17.69±4.52
Overall Quality of Life	2	2-10	4.88±0.53

Figure 1- exhibited the percentage distribution of social support dimensions among elderly participants in the study sample**.** As seen in this figure, the data showed the study sample not perceived social support in all dimensions except tangible support and appraisal support which also confirming that the study sample are more needed of different types of social support.

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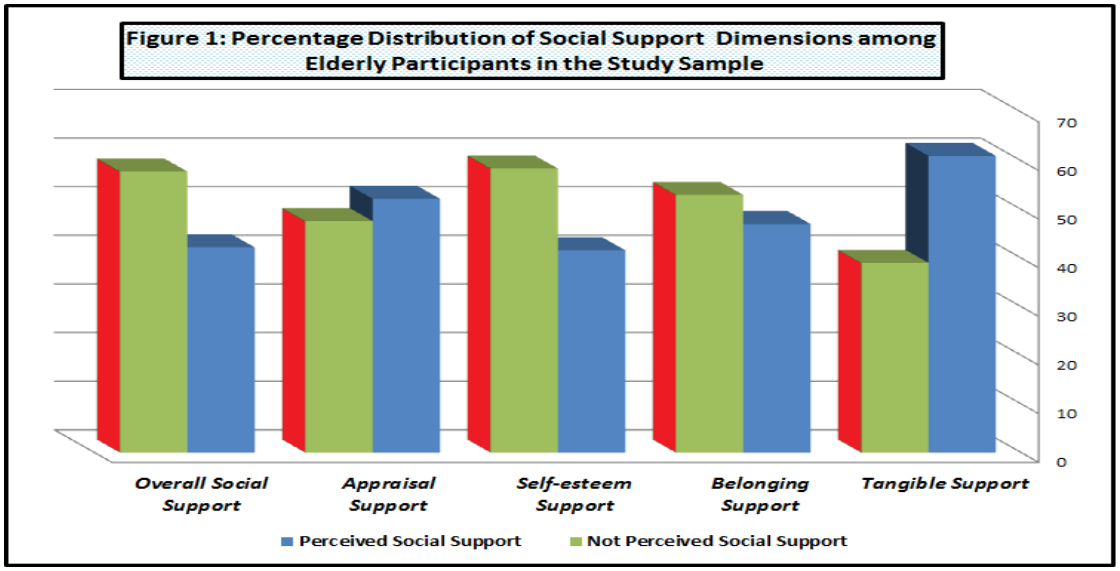

Figure 2- disclosed the percentage distribution of quality of life domains among elderly participants in the study sample**.** As comprehended in this figure, the result showed the study sample have poor quality of life in all domains except psychological and environment domains.

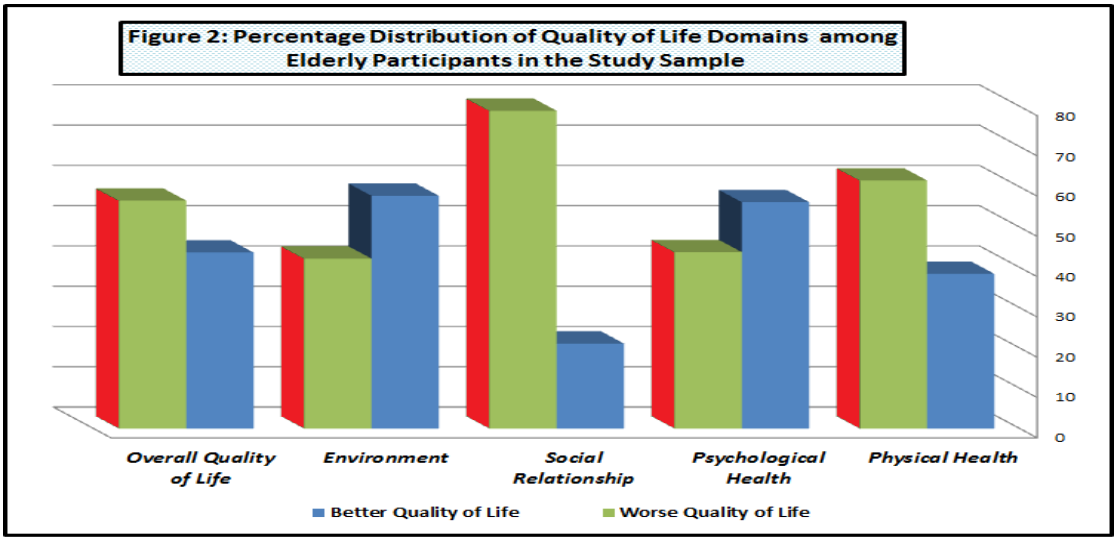

Table 3- presents the socio-demographic characteristics in relation to social support and quality of life among the elderly participants in the study sample. As seen in table no. 3, the findings exhibited that the mean age of the study sample was (67.8 $\pm$ 8.64). The participants of the study sample who are perceived social support was related to young-old and old age groups compared to the oldest-old group. Of the participants, 58.4% were female and the results of the present study indicated that males are perceived social support more than females. One third of the study sample, 33.5% were married who are perceived social support compared to divorced and widows participants. The highest percent of the study sample participants who had complete middle and secondary school are perceived social support more than the participants, who are less educated for example the participants who had a primary school or who are not able to read and write.

As concluded from this table, there was a significant negative association between older participants who perceived social support and their age (X^2 = - 8.29; p=. 043). While there was a positive association between older participants who perceived social support and their gender & educational background (X^2= 6.93; p =.025 & X^2=24.51; p=. 000) respectively. Similarly, in this study the findings revealed that there was a negative association between quality of life (QoL) and age groups (X^2 =-.191; p =.009), while there was a positive association between QoL and the participants' gender & education background (X^2=3.82; p= .032 & X^2=17.13; p=.002) respectively.

For the marital status, the highest percentage of group who perceived social support 33.5% was significantly related to married participants. In contrast, the lowest percentage of group who perceived social support was significantly related to divorced and widowed (1.6 % and 3.3 %) respectively. A statistical significant difference was found between marital status and levels of social support (X^2 =15.81; p=. 001). Similarly there was a statistical significant difference was found QoL between marital status (X^2 =12.73; p=. 005).

Furthermore the patterns of living arrangement, the result exhibit the highest percentage of group who perceived social support (24.3%) was significantly related to participants who live with their family. A statistical significant difference was found between patterns of living arrangement and levels of social support (X^2= 8.01; p=. 018). In addition, the finding indicates that the highest percentage of group (27%) who have better quality of life was significantly related to participants who living with the family. A statistical significant difference was found between the patterns of living arrangement and quality of life (X^2= 8.45; p=. 015).

At the same time, the results displayed the highest percentage of group who perceived social support (35.1%) was significantly related to participants who live with extended family compared to nuclear family. A statistical significant difference was found between types of family and levels of social support (X^2= 1.09; p=. 000). Likewise, the finding indicates that the highest percentage of group (31.9%) who have better quality of life was significantly related to participants who lives with extended family compared to the participant group who lives with the nuclear family. A statistical significant difference was found between types of family and QoL (X^2= 15.7; p=. 000).

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Table (3): Socio-demographic Characteristics in Relation to Social Support and Quality of life among the Elderly Participants in the Study Sample

Socio-demographic Characteristics	Study Sample (n = 185)	Social Support Levels		X^2 (p)	Quality of Life Levels		X^2 (p)
		Perceived Social Support (n=71)	Not Perceived Social Support (n=114)		Better QoL (n=82)	Worse QoL (n=103)	
Age /yr.	n (%)	n (%)	n (%)		n (%)	n (%)	
Young-old (60 –74 years)	96(51.9)	29 (15.7)	67(36.2)		32(17.3)	64(34.6)	
Old (75–84 years)	69(37.3)	31 (16.8)	38 (20.5)	-8.29	38(20.5)	31(16.8)	-.191
Oldest-old (85 + years)	20(10.8)	11 (5.9)	9 (4.9)	(.043*)	12(6.5)	8(4.3)	(.009*)
Mean ± SD			(67.8 ± 8.64)				
Gender							
Male	77(41.6)	45(24.3)	32(17.3)	6.93	45(24.3)	32(17.3)	.3.82
Female	108(58.4)	26(14.1)	82(44.3)	(.025*)	37(20.0)	71(38.4)	(.032*)
Marital Status							
Single	28(15.1)	0(0.0)	28(15.1)		18(9.7)	10(5.4)	
Married	112(60.5)	62(33.5)	50(27.0)	15.81	59(31.9)	53(28.6)	12.73
Divorced	9(4.9)	3(1.6)	6(3.3)	(.001**)	2(1.1)	7(3.8)	(.005**)
Widowed	36(19.5)	6(3.3)	30(16.2)		3(1.6)	33(17.8)	
Levels of Education							
Not Able to Read & Write	17(9.2)	3(1.6)	14(7.5)		6(3.3)	11(5.9)	
Primary School	29(15.6)	10(5.4)	19(10.3)		13(7.0)	16(8.6)	
Middle School	60(32.4)	15(8.1)	45(24.3)	24.51	18(9.7)	42(22.7)	17.13
Secondary School	58(31.4)	37(20.0)	21(11.4)	(.000*)	38(20.5)	20(10.8)	(.002**)
College	21(11.4)	6(3.3)	15(8.1)		7(3.8)	14(7.6)	
Pattern of Living Arrangement							
Alone	76(41.1)	17(9.2)	59(31.9)	8.01	14(7.6)	62(33.5)	8.45
Live with Family	83(44.9)	45(24.3)	38(20.5)	(.018*)	50(27.0)	33(17.8)	(.015*)
Live with Significant Relatives	26(14.0)	9(4.9)	17(9.2)		18(9.7)	8 (4.3)	
Types of Family							
Nuclear Family	77(41.6)	6(3.3)	71(38.4)	1.09	23(12.4)	54(29.2)	15.7
Extended Family	108(58.4)	65(35.1)	43(23.2)	(.000**)	59(31.9)	49(26.5)	(.000**)

*p < 0·05 **p < 0·001

Table 4- displayed the severity of comorbid condition is related to social support and quality of life of the elderly participants in the study sample. The result in this table exhibited the highest percentages of groups who perceived social support were (13.0% and 19.5%) which is related to participants who have mild and moderate co-morbidity respectively. The result shown that, there no a statistical significant difference was found between severity of comorbidity and

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levels of social support (X^2 = 5.04; p=. 080). In addition, the finding indicates that the highest percentage of group (23.2%) who have better quality of life was significantly related to participants who have moderate-comorbidity, while the lowest percentage of group (6.5%) who have better quality of life was significantly related to participants who have severe-comorbidity. A statistical significant difference was found between severity of the co-morbidity and QoL (X^2= 15.62; p=. 005).

Table (4): Co-morbidity Levels in Relation to Social Support and Quality of Life among the Elderly Participants in the Study Sample

Co-morbidity Levels	Study Sample (n = 185)	Social Support Levels		X^2 (p)	Quality of Life Levels		X^2 (p)
		Perceived Social Support (n=71)	Not Perceived Social Support (n=114)		Better QoL (n=82)	Worse QoL (n=103)	
	n (%)	n (%)	n (%)		n (%)	n (%)	
Mild Co-morbidity	74(40.0)	24(13.0)	50 (27.0)		27(14.6)	47(25.4)	
Moderate Co-morbidity	93 (50.3)	36 (19.5)	57 (30.8)	5.04 (.080)	43(23.2)	50(27.0)	15.62 (.005**)
Severe Co-morbidity	18(9.7)	11(5.9)	7 (3.8)		12 (6.5)	6(3.2)	

*p < 0·05 **p < 0·001

Table (5) revealed a significant difference between groups of participants who perceived and not perceived social support and all the quality of life domains. This table was found a significant difference between the social support groups and physical health domain (X^2 = -27.2; p= .000); and the significant difference between the social support groups and psychological health domain (X^2 =66.39; p= .000); while the significant difference between the social support groups and social relationship domain was (X^2 =12.16; p= .000); and finally the significant difference between the social support groups and environment domain and social support was (X^2 =10.77; p= .001).

Table (5): Difference in the Quality of Life among the Elderly Participants who Perceived or Not Perceived Social Support

Quality of Life Domains	Social Support Levels		X^2	P-value
	Perceived Social Support (n=71)	Not Perceived Social Support (n=114)		
	n (%)	n (%)		
Physical Health				
Better QoL	54(29.0)	36(19.4)	-27.2	.000**
Worse QoL	17(9.2)	78(42.2)		
Psychological Health				
Better QoL	69(37.3)	35(18.9)	66.39	.000**
Worse QoL	2(13.3)	79(42.7)		
Social Relationships				
Better QoL	22(11.9)	17(9.2)	12.16	.000**
Worse QoL	49(26.5)	97(52.4)		
Environment				
Better QoL	50(27.0)	45(24.3)	10.77	.001**
Worse QoL	21(11.4)	69(37.3)		

*p < 0·05 **p < 0·001

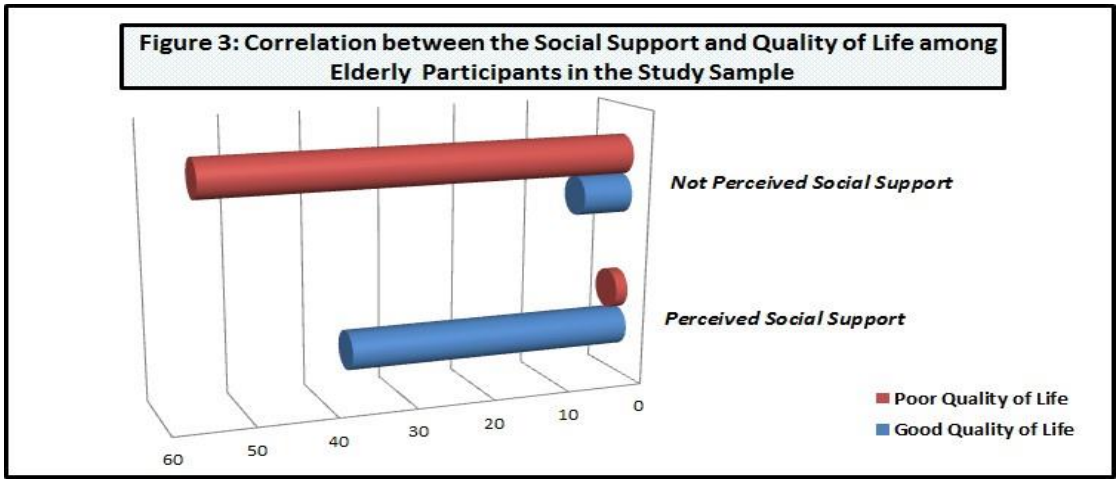
Table 6 – Indicated that there is a positive association between social support and the quality of life among the elderly participants in the study sample (r = .175 ; p= .017).

Table (6): Correlation between Social Support and Quality of Life among Elderly Participants in the Study Sample

Variables	Social Support Levels			r	P value
	Overall Social Support (n=185)	Perceived Social Support (n=71)	Not Perceived Social Support (n=114)		
	n(%)	n (%)	n (%)		
Overall QoL					
Better QoL	80(43.2)	68(36.8)	12(6.5)	.175	.017*
Worse QoL	105(56.8)	3(1.3)	102(55.1)		

*p < 0·05 **p < 0·001

Figure 3- In this figure, the result indicated that the highest percent of the elderly participants in the study sample who perceived social support (36.8%), they have a better quality of life. In contrast, the highest percent of the elderly participants who not perceived social support (55.1%), they have a worse quality of life.



4.0 DISCUSSION

Social support is the perception that one is cared for, has assistance available from other people, and most popularly, that one is part of a supportive social network. The presence of social support significantly predicts the individual's ability to cope with stress and improve a person's well-being. Therefore, social support is critical for elderly people particularly who often have chronic illnesses that may be directly interfering with the quality of their lives.

Socio-demographic Factors that Affecting Social Support

In this study, the results presented that the participants of the study sample who are perceived social support was related to young-old and old-age groups compared to the oldest-old group. There was significant a negative correlation between age - groups and levels of social support. This result was consistent with Bélanger et al., (2016); Dai et al., (2016) who stated that there is a significant negative correlation between age and social support. Multiple linear regression analysis, with social support as a dependent variable, retained the following independent predictors in the final regression model: age (-0.805, 95% CI: -1.394 to -0.135, P=0.013). [7,17]

Furthermore, the result of the current study showed that there was a negative association between quality of life (QoL) and age groups. This finding was agreed with (Ning et al., 2013;Yang et al.,2012) who stated that health-related quality of life (HRQOL) among subjects is declined with age and there is varied significantly ($p>0.05$) by age in both males and females.[18,19] In addition, the results of other studies that done by (Serap et al.,2016; Marek et al., 2013), who have been presented that there is a statistically significant relationship was found between age and quality of life, the calculated odds ratios confirmed that the possibility of enjoying good life is greater for younger respondents and older age is one of the situations that leads to quality of life was decreased.[20,21]

In addition, the results of the present study indicated that males are perceived social support more than females. There was correlation between gender and social support. This finding was in agreement with (Dai et al., 2016; Serap et al.,2016) who reported that

there is a strong association between gender and social support (p>0.05).[17,20] According to Eleni et al.,(2014) who illuminated that female family members were more involved in providing social support for the patient and the children in the family compared with male family members.[22]

In relation to the gender and quality of life, the current result of this study was illustrated that a significant correlation was found between gender and quality of life. This result is supported by other studies (Serap et al.,2016; Orfila et al.,2006) who specified that the socio-demographic factors that affected the quality of life of the elderly people such as sex, marital status, education, and annual household income. These factors are positively associated with the QoL of the elderly participants. In addition, other studies findings found 65.4 % of the elderly women showed worse QoL and functional capacity compared to men (mean QoL index score was higher among men than women; p= 0.007).[20,23]

For the marital status, the result of this study showed that married elderly participants are more perceived social support compared with divorced and widowed. This finding was also described in many researches by (Penning and Wu ,2014; Hewitt et al., 2012), who contended that widowed, single , and divorced elderly had experience of poor social support compared with married elderly.[24,25] This result aligned with (Serap et al., 2016) study, which describes married participants had higher family subgroup scores of social support scale compared to widows (p= .0017) and the participants who are living with their spouse had better social support family subgroup scores compared to the ones living alone (p= .0017).[20] According to (Dai et al.,2016) declared that the social support was significantly correlated with marital status where the multiple linear regression analysis, with social support as a dependent variable, retained the following independent predictors in the final regression model: marital status (-1.260, 95% CI:-1.891 to -0.629, P=0.000).[17]

Furthermore, The results of the present study showed that QoL is better among married elderly participants compared to single, widow and divorced. These results are in agreement with previous studies which confirmed that the marital status was also a significant factor that affecting QoL where the mean score of the QoL index was higher among married participant compared to the elderly people who remain single or have lost their spouse , often have poor quality of life (p= 0.003).[20,21]

The results of the current study showed that elderly participants of the study sample who had complete middle and secondary school are perceived social support more than the participants who are less educated. The current result is consistent with many other studies found that the elderly people who have a higher educational level may have better communication ability and interpretation skills so they can utilize support resources actively and joined with higher social class and economic status. In addition, another study quantified that the social support was significantly correlated with education where the multiple linear regression analysis, with social support as a dependent variable, retained the following independent predictors in the final regression model: education (1.697, 95% CI: 0.589–2.805 P=0.003).[17,20]

Also the current study revealed that education was a significant positive correlation with the quality of life. This result is in agreement with Belanger et al.,(2017); Marek et al., (2013); Akinyemi (2012); Tian et al., (2011); Lasheras et al., (2001) who simplified that educational background had a significant correlation to overall HRQOL, where lower educational level is often associated with loss of happiness, poor social relationship, poor self-assessed health and sensory problem among elderly people. [7,21,26,27,28] At the same time, they reported that education is an important indicator that may impact on the HRQOL through its association with higher class and economic status. On the other hands, other previous studies described that education level is associated with better HRQOL; and university educational level among older adults is associated with happiness and enjoying good life more than twice (OR - 2.31, P= <0.05). Additionally, a higher educational level among older adults is associated with higher incomes and better social support with no medical cost burden. [18,26]

In accordance to this study, the finding showed that there is a positive correlation between social support and the older participants who live with their family compared to the older participants who are living alone . This result is a line with Shin and Sok (2012) who confirmed the current result and reported that older people who are living with their family were better than older people who are living alone in perceived health status, self-esteem, and life satisfaction.[29] Additionally, the present results are supported by (Belanger et al.,2016; Ning et al.,2013) who stated that the high levels of social support by the family members were associated with better health and also high support from partner was associated with good health. In contrast, elderly people who have low support from family and their children was associated with poor health . In addition, high level of social support from children, family members, and partner all related with a lower prevalence of depressive symptoms. [7,18]

In the current study, there was found a positive relationship between quality of life and the older participants who live with their family compared to the older participants who are living alone. These results are confirmed with (Serap et al.,2016) who stated that the family is still the main system that provide emotional and social support. [20] This came from the traditional family culture since ancient years and this connection brings better, social networks, which have positive effects on quality of life of older adults. It was also reported that 67% of older people stated the source of happiness for them as their families. [30] According to Fratigloni et al., (2004) who reported that surviving an active and social lifestyle in late life might have protective effects against dementia, strengthening the ties with life tightened. [31]

On the other hand , the present results was an agreement with (Ning et al., 2013) who reported a mean score of HRQOL dimensions of elderly subjects who are living alone were low.[18] According to Litwin, (2010) who confirmed and extended previous research conducted in Europe comparing social support in five Mediterranean countries with seven countries of Northern Europe which testified that family support is more important in Mediterranean countries where there are more household exchanges.[32] Moreover, Zunzunegui et al., (2004) found that comparing two francophone older Canadian

populations, one from a working class neighborhood population of Montreal, and the other from the middle class city of Moncton, New Brunswick, in Montreal, having family and children was associated with good health, whereas having low support from children was associated with poor health. (33)

For the current study, the result was found a significant correlation between social support and the participants who live with extended family compared to nuclear family. This result supported by Eleni et al., (2017); Bélanger et al., (2016); Cecchini and Martínez (2012) who affirmed a strongest associations were seen when the support came from extended family, children and partner, whereas support from friends did not play a significant role. In fact, among study participants, having high levels of social support from family and partner was related to good health, and having high support from children was also related to less depression and better quality of life. Quality of life was related to receiving high levels of support from the partner, and those with poor support from children appeared to have worse quality of life than those without children. Also the result concludes that in Canada and South Asian, although there are an importance of relationships with friends, but the presence of a partner is more important than the quality of support, which is different from the results in Latin America where not merely the presence of the social tie, but the levels of support from family members, children and partner are significantly associated with older adults' health and well-being. (22,7,34)

Association between Severity of Comorbidity Condition and Social Support & Quality of Life

As concluded from the current study, the results designated that there is no significant relationship between the participants who perceived social support and the levels of severity of comorbidity condition. This result is supported by (Horasan, 2013;and Kalaça, 2013) who are reported that older persons who obtained emotional support only outside their family, they did not report significantly different health status compared to the older persons who received emotional support from both family and community members. (35,36) In contrast, this result is in disagreement with (Ann et al.,2009) who stated that older persons who received social support from both family and community members, they had reported better health than who didn't receive . Also, older men who could not identify any source of emotional support had reported poor or fair health versus very good or excellent health 2 times more than older men who received emotional support from both family and community members (OR=2.56; 95% CI=1.47, 4.47; P<.001). Similarly, older women who considered only their relatives to be emotionally supportive had reported poor/fair health compared with very good/excellent health 1.4 times more often than did women who obtained emotional support from both family and community members (95% CI=1.05, 1.91; P<.05). (37)

Regarding for the correlation between the severity of the co-morbid condition and quality of life . The results of the present study confirmed that there is a significant correlation between severity of the co - morbid condition and quality of life of the elderly participants

in the study sample. This result is supported by several researches that reported chronic diseases had a major impact on the HRQOL of the elderly subjects where chronic diseases were also associated with lower QOL. [18,38,39]

Association between Social Support and Quality of Life

As specified in the results of the present study, there are a strong correlation between social support and all quality of life domains among elderly participants in table (5). The result of the current study showed a negative correlation between social support and physical health domain among elderly participants in the study sample (x^2 = -27.2; p= .000). This results supported by Varsha S.,(2017) who stated that there is a negative correlation between social support and physical health which indicates to if social support increases the physical health decreases. [40] Furthermore, this result was consistent with (Chen and Meng,2015; Hurtado et al., 2011, Serap et al., 2017) who reported that social support is regarded as the mechanism that links social capital and health outcomes, the association between social support and self-rated health may be either direct (e.g., provision of health information) or indirect (e.g., help with a job search, which promotes health). Furthermore, individual features of social support can be considered to be a resource for the health and well-being of older people. As the social support increased, quality of life of older adults improved. [41,42,20]

Additionally, the result of the current study showed a positive correlation between social support and psychological health domain among elderly participants in the study sample (x^2 = 66.39 p=.000) . This result is inconsistent with (Varsha S.,2017) who stated that there is a weak correlation between social support and psychological health domain. [40] Another study by (Garcia et al.,2003; Kahn et al.,2003) was found that older adults who had poorer social network had also worse quality of life and also found a quite strong relationships between perceived social support and psychological well-being (depression, loneliness and life satisfaction). [43,44] In addition, Garousi et al., (2013) study reported a positive relationship was found between social support and quality of life of elderly. In this study, emphasized that supportive family behaviors are important sources of social support and could be in a negative relation to depression and anxiety of diabetic patients. [45]

The results of this study showed the positive correlation between social support and social relationships domain among elderly participants in the study sample (x^2= 12.16 p=.000). Other studies confirmed by (Varsha S.,2017; Shin and Sok,2012) who stated that there is a strong and significant correlation between social support and social relationship that include facets such as personal relationships with their family members, friends, neighbors as important sources for support to elderly and help to overcome stress and feelings of despair. [40,29] Other studies by (Monserud & Wong , 2015; Deshmukh et al.,2015; Kahn et al., 2003) found correlations between social support and well-being measures among older people because some older people become dependent to other close people for their support to overcome of their complex health problems, being isolated from society , feel anxiety , depression, loneliness and hopelessness. Thus, there is a reciprocity and exchange of the affect among provide support and enhances one's overall quality of life. [46 ,47,44]

As inferred from the results of this study showed the positive correlation between social support and environment domain among elderly participants in the study sample (x^2=10.77; p=.001). This result inconsistent with (Varsha S.,2017) who stated that there is no correlation between social support and environment that include facets such as social care accessibility and quality ; physical safety and security; and financial resources.[40] While, another study was in agreement with (Wang et al.,2018; Dai et al.,2016; Lin et al., 2014; Wacker and Roberto ,2013) who showed that availability ideal ageing policies that greatly support the participation of elderly people in social, economic, and cultural, and spiritual activities, helping them to maintain a large social network. In addition, increase expenditure on health care, and social care caused by an aging population that may directly meet the great support demands of older people.[48,17, 49,50]

5.0 CONCLUSION AND RECOMMENDATIONS

Social support is a contributing factor to enhance quality of life among the older adult participants. Therefore, this study recommended that all the health care providers, particularly the nurses to perform a careful investigation of the older adults through review of factors that might be directly affected social support and may have influence on their quality of life. Hence the professional nurse can play an important part in recognizing the elderly adults who may potentially be experiencing loss of social support and need referral for providing a social support to avoid deterioration of the quality of their lives.

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