



IMPACT OF GERIATRIC HEALTH CARE PROGRAM ON IMPROVING QUALITY OF LIFE AMONG GERIATRICALS IN SELECTED RURAL AREA

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Abstract:

Aging, increased life expectancy, advances in health care, and demographic transition have significantly influenced the quality of life (QOL) of older adults. Older people living in rural communities may experience several physical, psychological, social, and environmental challenges that adversely affect their well-being. A comprehensive geriatric health care programme addressing these dimensions may contribute to improving their quality of life. The present study was undertaken to assess the impact of a geriatric health care programme on the quality of life among geriatric people in a selected rural area.

Materials and Methods:

A quantitative experimental approach with a one-group pre-test and post-test research design was adopted. The study included 110 geriatric people aged 60–70 years. Participants were selected using a simple random sampling technique by the lottery method. Data were collected using the World Health Organization Quality of Life (WHOQOL) scale. A structured geriatric health care programme was administered as an intervention. Pre-test and post-test quality of life scores were assessed and compared using descriptive and inferential statistics.

Results:

In the pre-test, 86 (78.18%) participants had average poor quality of life and 24 (21.82%) had poor quality of life, while none had good quality of life. In the post-test, 73 (66.36%) participants had good quality of life and 37 (33.64%) had average quality of life, with none having poor quality of life. The mean physical health domain score increased from 17.60 ± 1.38 to 23.74 ± 1.53 ($t = 31.725$, $p < 0.001$). The psychological domain increased from 13.09 ± 1.92 to 21.98 ± 1.41 ($t = 36.978$, $p < 0.001$). The social relationship domain increased from 5.58 ± 1.21 to 12.27 ± 1.18 ($t = 41.828$, $p < 0.001$), and the environmental domain increased from 14.48 ± 2.63 to 31.71 ± 2.13 ($t = 51.449$, $p < 0.001$). The overall QOL mean score increased from 53.73 ± 4.61 to 98.53 ± 3.43 , with a paired t -value of 78.639 ($p < 0.001$).

Conclusion:

The findings demonstrated a statistically significant improvement in physical, psychological, social relationship, environmental, and overall quality of life following implementation of the geriatric health care programme. The study suggests that a structured geriatric health care programme may be an effective intervention for enhancing the quality of life of older adults residing in rural communities.

Keywords: Geriatric Health Care Programme, Quality of Life, Geriatric People, Older Adults, Rural Area.

1.Introduction:

Older adults living with chronic diseases are at a greater risk of developing dependency than those who do not have long-term health conditions. Their health-related behaviours are influenced by several factors, including personal motivation, family support, and the home environment (World Health Organization [WHO], 2020).¹ Healthy lifestyle practices, such as maintaining a balanced diet, engaging in regular physical activity, adhering to prescribed medications, and attending routine health check-ups, are often shaped by family habits and daily routines. For example, older adults may consume unhealthy foods when such dietary patterns are common within the household. Therefore, understanding family dynamics is essential when designing interventions to encourage healthy behaviours among older adults (Whitehead et al., 2017).²

Family members play a vital role in providing emotional, social, and practical support to older adults with chronic illnesses. Their involvement can facilitate effective self-care and disease management by encouraging medication adherence, healthy eating, regular exercise, timely medical consultations, and compliance with recommended treatment plans (Whitehead et al., 2017).² Evidence from previous studies suggests that appropriate family support can promote the maintenance of healthy behaviours and contribute to improved health outcomes. Nevertheless, family members may lack sufficient knowledge about chronic diseases, their signs and symptoms, treatment options, and the specific care needs of older adults. Furthermore, the demands associated with caregiving can result in physical exhaustion, emotional stress, and reduced motivation to participate in health-promoting activities (Choi et al., 2024; Isac et al., 2021).³ Consequently, providing education, guidance, and encouragement to family members is important for strengthening their involvement in elderly care and supporting effective disease management.

The Theory of Planned Behavior (TPB) provides a theoretical framework for understanding the factors that influence individual health behaviours. According to this theory, behavioural intentions are primarily determined by attitudes toward the behaviour, subjective norms, and perceived behavioural control (Ajzen, 1991).¹ These components influence an individual's willingness and perceived ability to perform a particular action. The theory also recognizes that successful behavioural performance depends on both intention and the availability of necessary resources and opportunities. The TPB has been widely used to explain and predict health-related behaviours and can guide the development of interventions that address individual beliefs, social influences, and perceived barriers (Ajzen, 1991).¹ Applying this theory may help promote sustainable healthy practices among older adults through increased family involvement and supportive home environments.

2.Background:

Singh et al. (2022) conducted a cross-sectional study among 430 older adults aged 60 years and above in rural India to assess health-related quality of life using the WHOQOL-BREF questionnaire. The findings revealed that 67.7% of participants had chronic morbidity, while 46.7% experienced poor overall quality of life. Older age, low socioeconomic status, lack of education, absence of a spouse, and chronic illness were associated with poorer quality of life. The study emphasized the need for preventive and promotive geriatric health care services.⁶

Krishnappa et al. (2021) conducted a community-based cross-sectional study involving 977 older adults in rural and urban Bangalore, South India. Using the WHOQOL-BREF questionnaire, the researchers found lower quality-of-life scores among rural older adults across physical, psychological, social, and environmental domains compared with urban participants. The study highlighted the importance of improving health care accessibility and social support.⁷

Dongre et al. (2012) investigated the social determinants of quality of life among older adults in rural central India using quantitative and qualitative methods. The findings identified family relationships, financial security,

meaningful activities, social participation, and access to health care as important factors influencing well-being. The study recommended comprehensive geriatric care addressing physical, psychological, and social needs.⁸

(2023)A study involving 440 older adults in Dehradun evaluated the Hindi version of WHOQOL-OLD. The questionnaire demonstrated good internal consistency, with a Cronbach's alpha coefficient of 0.86. It was considered suitable for assessing autonomy, sensory abilities, social participation, and intimacy.⁹

Von Steinbüchel et al. (2006) evaluated the WHOQOL-BREF among 262 older adults and reported satisfactory reliability and validity, supporting its use in assessing multiple quality-of-life domains.¹⁰

Peel et al. (2007) supported the reliability and validity of WHOQOL-OLD for assessing age-specific quality-of-life dimensions, including autonomy and social participation.¹¹

Rural Maharashtra Intergenerational Program (2026) An evaluation involving 520 older adults across 18 villages found qualitative improvements in social relationships, although sustained quantitative improvements in quality-of-life scores were not demonstrated. This highlights the importance of systematically evaluating geriatric health care interventions.¹² A comprehensive geriatric health care programme addressing these dimensions may contribute to improving their quality of life. The present study was undertaken to assess the impact of a geriatric health care programme on the quality of life among geriatric people in a selected rural area.

3.Problem Statement:

Impact of Geriatric Health Care Programme on Improving Quality of Life among Geriatric People in a Selected Rural Area.

4.Objectives:

1. To assess the pre-test quality of life among geriatric people.
2. To assess the post-test quality of life among geriatric people.
3. To determine the impact of the geriatric health care programme on quality of life.
4. To determine the association between quality of life and selected demographic variables.

5.Hypotheses:

H0: There is no significant improvement in quality of life following the intervention.

H1: There is a significant improvement in quality of life following the intervention.

H01: There is no significant association between pre-test quality of life scores and selected demographic variables.

H2: There is a significant association between pre-test quality of life scores and selected demographic variables.

All hypotheses will be tested at the 0.05 level of significance.

6.Research Approach:

A quantitative evaluative approach was adopted for the present study to assess the effectiveness of the geriatric health care programme in improving the quality of life among older adults.

7.Research Design:

A quasi-experimental, one-group pre-test and post-test research design was used. The quality of life of the participants was assessed before and after implementation of the geriatric health care programme.

8.Setting of the Study:

The study was conducted in a selected rural village where the required geriatric population was available and data collection could be carried out effectively.

9.Target and Accessible Population:

Target Population: The target population comprised geriatric people aged 60–70 years, including both males and females.

Accessible Population: The accessible population consisted of geriatric people aged 60–70 years residing in the selected rural village.

10.Sample and Sample Size:

The sample consisted of geriatric people aged 60–70 years. The planned sample size was 100 participants. Considering a 10% attrition allowance, the final sample size was increased to 110 participants.

11.Sampling Technique:

A simple random sampling technique using the lottery method was employed to select 110 eligible geriatric participants, including both males and females.

12.Eligibility Criteria:

Inclusion Criteria: Participants who:

1. Were aged 60–70 years.
2. Included both male and female geriatric people.
3. Were able to perform their routine physical activities independently.
4. Were able to read and understand Marathi or Hindi.

Exclusion Criteria: Participants who:

1. Had a documented history of psychiatric disorders.
2. Were unable to speak, read, or understand Marathi or Hindi.

13.Variables:

Independent Variable: Geriatric health care programme.

Dependent Variable: Quality of life among geriatric people.A 26-item WHOQOL questionnaire

Demographic Variables: Age, gender, religion, educational status, occupation, marital status, type of family, monthly income, major source of income, caregiver during illness, and presence of comorbidities.

14. Methods of Data Collection and Tool:

Section A: An 11-item structured questionnaire was used to collect participants' sociodemographic information.

Section B: A 26-item WHOQOL questionnaire was used to assess quality of life across four domains: physical health, psychological health, social relationships, and environmental health.

15.Result:**SECTION A: Describing the frequency and percentage distribution of socio demographic variables of geriatrics.**

Table No. Frequency and percentage distribution of socio demographic variables of geriatrics.

N=110

Sr. No	Demographic Variables	Category	Frequency	Percentage
1	Age in years	56-60 years	11	10.00
		61-65 years	38	34.55
		65-70 years	43	39.09
		More than 70 years	18	16.36
2	Gender	Male	61	55.45
		Female	49	44.55
3	Religion	Hindu	49	44.55
		Buddha	34	30.91
		Muslim	23	20.91
		Christian	4	3.64
4	Educational status	Illiterate	31	28.18
		Primary	56	50.91
		Secondary	22	20.00
		Graduate	1	0.91
5	Occupation	Farmer	38	34.55
		Daily wages	16	14.55
		Retired serviceman	12	10.91
		House wife	16	14.55
		Employee	28	25.45
6	Type of Family	Joint family	53	48.18
		Nuclear family	57	51.82
7	Marital Status	Single	16	14.55
		Married	81	73.64
		Widow	13	11.82
8	Monthly Income	Rs. <5000/-	33	30.00
		Rs. 6000 - 10,000	49	44.55
		Rs. 11,000 - 15,000	20	18.18
		Rs. 16,000 – 20,000		
		& above	8	7.27

9	Major source of income	Couple	37	33.64
		Son	65	59.09
		Daughter	5	4.55
		Pension	3	2.73
10	Who are care taker when you are sick?	Spouse	46	41.82
		Son	52	47.27
		Daughter	2	1.82
		Daughter in law	2	1.82
		Grand child	8	7.27
11	Do you have any co-morbidity?	Diabetes Mellitus	30	27.27
		Hypertension	37	33.64
		Asthma	3	2.73
		Dementia	10	9.09
		Any Others	30	27.27

The demographic characteristics of the 110 older adults revealed that the largest proportion (39.09%) belonged to the 65–70 years age group, followed by 34.55% in the 61–65 years age group. Regarding gender, 55.45% were male and 44.55% were female. In terms of religion, 44.55% were Hindu, 30.91% were Buddhist, 20.91% were Muslim, and 3.64% were Christian. With respect to educational status, 50.91% had primary education, while 28.18% were illiterate, 20.00% had secondary education, and 0.91% were graduates.

Regarding occupation, 34.55% were farmers, 25.45% were employees, 14.55% were daily wage workers, 14.55% were housewives, and 10.91% were retired servicemen. More than half (51.82%) belonged to nuclear families, while 48.18% lived in joint families. Most participants (73.64%) were married, whereas 14.55% were single and 11.82% were widowed.

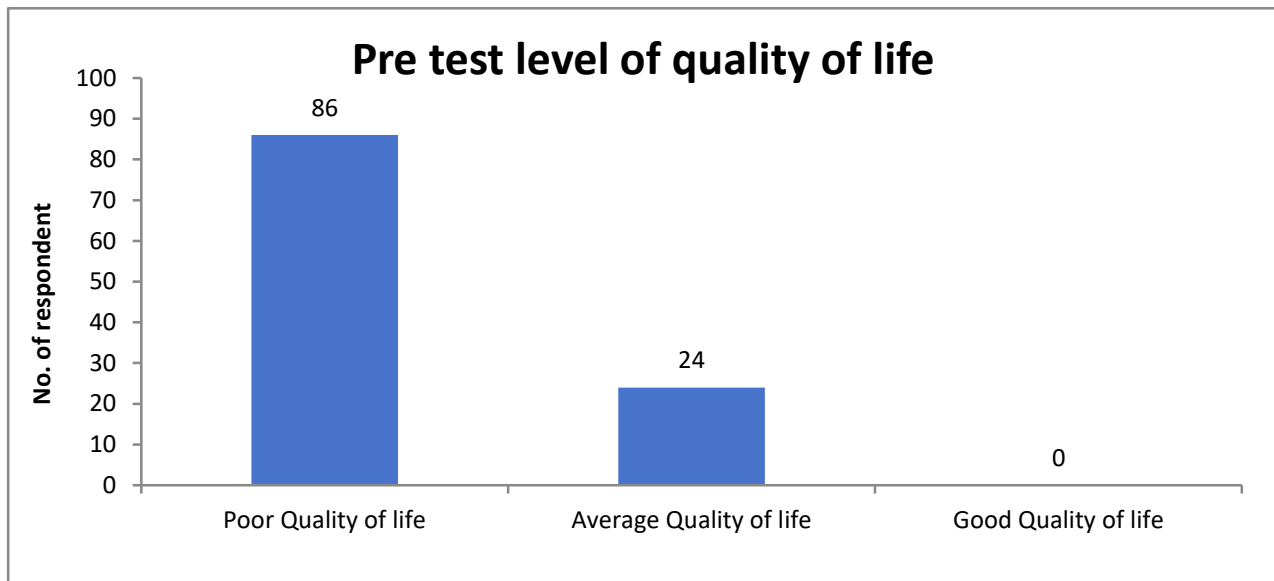
Concerning monthly income, 44.55% reported an income of Rs. 6,000–10,000, while 30.00% had an income below Rs. 5,000. The major source of income was the son for 59.09% of participants, followed by the couple for 33.64%, the daughter for 4.55%, and pension for 2.73%. Regarding caregiving during illness, 47.27% depended on their sons, while 41.82% relied on their spouses. Grandchildren provided care for 7.27% of participants, whereas daughters and daughters-in-law each cared for 1.82%.

Regarding comorbidities, hypertension was the most frequently reported condition (33.64%), followed by diabetes mellitus (27.27%) and dementia (9.09%). Asthma was reported by 2.73% of participants, while 27.27% had other comorbid conditions. Overall, the findings indicate that most participants were married, belonged to nuclear families, had primary education, and relied primarily on their sons for financial support and caregiving.

SECTION B: To assess level of quality of life among geriatrics.

1. Assess pretest level of quality of life among geriatrics.

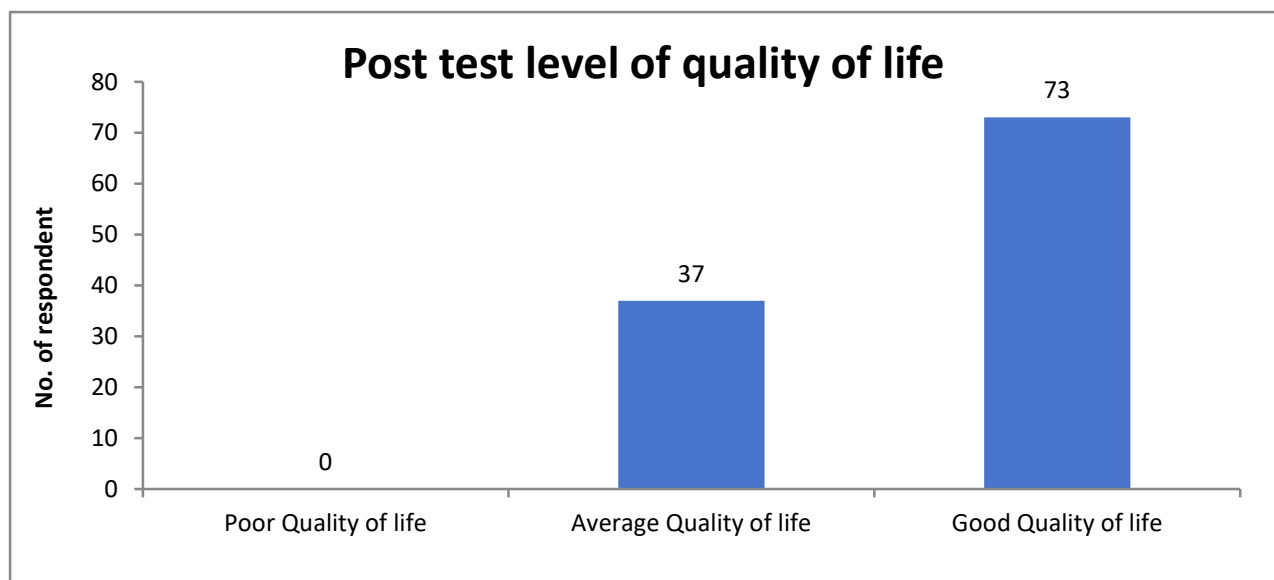
N=110



In the pre-test, 86 (78.18%) participants had average poor quality of life and 24 (21.82%) had poor quality of life, while none had good quality of life.

2. Assess post-test level of quality of life among geriatrics.

N=110



In the post-test, 73 (66.36%) participants had good quality of life and 37 (33.64%) had average quality of life, with none having poor quality of life.

SECTION C: To evaluate Impact of geriatric health care programme on improving quality of life among geriatrics.

Table No. Evaluate Impact of geriatric health care programme on improving quality of life among geriatrics.

N=110

Sr. No	Domain	Group	Mean	Standard deviation	Mean %	paired t test	P value
1	Domain 1 Physical Health	Pre test	17.6	1.38	50.29	31.725	0.000
		Post test	23.74	1.53	67.83		
2	Domain 2 Psychology	Pre test	13.09	1.92	43.63	36.978	0.000
		Post test	21.98	1.41	73.27		
3	Domain 3 Social Relationship	Pre test	5.58	1.21	37.20	41.828	0.000
		Post test	12.27	1.18	81.80		
4	Domain 4 Environment	Pre test	14.48	2.63	36.20	51.449	0.000
		Post test	31.71	2.13	79.28		
Over all QOL		Pre test	53.73	4.614878	41.330769	78.639	0.000
		Post test	98.53	3.433526	75.792308		

The mean score in the physical health domain increased from 17.60 ± 1.38 to 23.74 ± 1.53 ($t=31.725$, $p<0.001$). The psychological domain increased from 13.09 ± 1.92 to 21.98 ± 1.41 ($t=36.978$, $p<0.001$). The social relationship domain increased from 5.58 ± 1.21 to 12.27 ± 1.18 ($t=41.828$, $p<0.001$), while the environmental domain increased from 14.48 ± 2.63 to 31.71 ± 2.13 ($t=51.449$, $p<0.001$). The overall QOL mean score increased from 53.73 ± 4.61 to 98.53 ± 3.43 , with a paired t-value of 78.639 ($p<0.001$).

SECTION D: To find out association between pre-test level of quality of life with their selected demographic variables of geriatrics.

Table No. Find out association between pre- test level of quality of life with socio demographic variables of geriatrics.

N=110

Sr. No	Socio demographic variables	Category	Pre-test Levels of quality of life				Total	Chi square value	p - value
			Poor		Average				
			f	%	f	%			
1	Age in years	56-60 years	9	81.82	2	18.18	11	0.701	0.873
		61-65 years	31	81.58	7	18.42	38		
		65-70 years	32	74.42	11	25.58	43		
		More than 70 years	14	77.78	4	22.22	18		
2	Gender	Male	47	77.05	14	22.95	61	0.103	0.748
		Female	39	79.59	10	20.41	49		

3	Religion	Hindu	39	79.59	10	20.41	49	2.587	0.460
		Buddha	24	70.59	10	29.41	34		
		Muslim	19	82.61	4	17.39	23		
		Christian	4	100.	0	0.00	4		
4	Educational status	Illiterate	24	77.42	7	22.58	31	3.760	0.289
		Primary	45	80.36	11	19.64	56		
		Secondary	17	77.27	5	22.73	22		
		Graduate	0	0.00	1	100.00	1		
5	Occupation	Farmer	33	86.84	5	13.16	38	5.367	0.252
		Daily wages	13	81.25	3	18.75	16		
		Retired serviceman	7	58.33	5	41.67	12		
		House wife	13	81.25	3	18.75	16		
		Employee	20	71.43	8	28.57	28		
6	Type of Family	Joint family	41	77.36	12	22.64	53	0.041	0.840
		Nuclear family	45	78.95	12	21.05	57		
7	Marital Status	Single	12	75.00	4	25.00	16	0.418	0.811
		Married	63	77.78	18	22.22	81		
		Widow	11	84.62	2	15.38	13		
8	Monthly Income	Rs. <5000/-	24	72.73	9	27.27	33	7.491	0.058
		Rs. 6000 - 10,000	43	87.76	6	12.24	49		
		Rs. 11,000 - 15,000	12	60.00	8	40.00	20		
		Rs. 16,000 – 20,000 & above	7	87.50	1	12.50	8		
9	Major source of income	Couple	27	72.97	10	27.03	37	2.824	0.420
		Son	51	78.46	14	21.54	65		
		Daughter	5	100.	0	0.00	5		
		Pension	3	100.	0	0.00	3		
10	Who are care taker when you are sick?	Spouse	39	84.78	7	15.22	46	4.577	0.333
		Son	37	71.15	15	28.85	52		
		Daughter	1	50.00	1	50.00	2		
		Daughter in law	2	100.	0	0.00	2		
		Grand child	7	87.50	1	12.50	8		
11	Do you have any co-morbidity?	Diabetes Mellitus	27	90.00	3	10.00	30	7.746	0.101
		Hypertension	30	81.08	7	18.92	37		
		Asthma	3	100	0	0.00	3		
		Dementia	7	70.00	3	30.00	10		

		Any Others	19	63.33	11	36.67	30		
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* Significant at the level of p 0.05.

Table No.: Shows that association between pretest level of knowledge regarding improving quality of life with Age in years, Gender, Religion, Educational status, Occupation, Type of Family, Marital Status, Monthly Income, Major source of income, Who are care taker when you are sick?, Do you have any co-morbidity? the chi square p value found to be 0.873, 0.748, 0.460, 0.289, 0.252, 0.840, 0.811, 0.058, 0.420, 0.333, and 0.101 respectively, it is no significant the level of 0.05. Ho1 accepted and H2 rejected.

15. Discussion:

The present study was conducted to assess the impact of a geriatric health care programme on improving the quality of life among geriatrics in a selected rural area. The findings of the study are discussed in relation to the objectives of the study.

Objective 1: To assess the pre-test quality of life among geriatrics

In the present study, 86 (78.18%) participants had an average/poor quality of life, while 24 (21.82%) had poor quality of life. None of the participants had good quality of life before the intervention. These findings indicate that the study population had considerable scope for improvement in quality of life.

A comparable Indian study, Health related quality of life among rural elderly using WHOQOL-BREF in the most backward district of India, assessed 430 older adults and reported that 46.7% had poor quality of life. The study also found that chronic morbidity was common among participants.¹⁵ Although the proportion with poor quality of life differed from that in the present study, both studies highlight the need to address the health and well-being of older adults in community settings. Differences may reflect variations in study populations, assessment methods, and the categories used to classify quality of life.

Objective 2: To assess the post-test quality of life among geriatrics

The present study showed a marked improvement after the geriatric health-care programme. In the post-test, 73 (66.36%) participants had good quality of life and 37 (33.64%) had average quality of life, while none remained in the poor-quality-of-life category.

These findings can be compared with Chen et al. (2021),¹³ who conducted a systematic review and meta-analysis of 28 randomized controlled trials evaluating comprehensive geriatric assessment interventions. Their findings showed a statistically significant, although small, improvement in quality of life compared with usual care (standardized mean difference = 0.12, 95% CI 0.03–0.21; p = .009). This supports the potential value of structured geriatric interventions, although the magnitude of improvement in that review cannot be directly equated with the categorical changes observed in the present study.

Objective 3: To determine the impact of the geriatric health-care programme on quality of life

In the present study, mean physical health scores increased from 17.60 to 23.74, psychological scores from 13.09 to 21.98, social relationship scores from 5.58 to 12.27, and environmental scores from 14.48 to 31.71. The overall mean score increased from 53.73 to 98.53. All reported paired t-tests were statistically significant (p < .001), suggesting substantial improvement in all four domains following the intervention.

These findings are consistent with the systematic review by Chen et al. (2021),¹³ which found that comprehensive geriatric assessment improved quality of life compared with usual care. However, evidence is not uniformly positive. A 2026 study by Jakasania et al. evaluated a community-based intergenerational programme across 18 villages in rural Maharashtra.¹⁴ Although the programme was associated with better intergenerational interaction, community participation, and perceived relationships, the reported quality-of-life scores did not increase over the three-year period. This contrast suggests that improvements in social engagement and health-related practices do

not necessarily translate into higher overall quality-of-life scores and that outcomes may depend on the type, intensity, and duration of the intervention.

Objective 4: To determine the association between pre-test quality of life and selected demographic variables

In the present study, no statistically significant association was found between pre-test quality of life and the selected demographic variables, as all reported p-values were greater than .05. This indicates that the study did not find sufficient statistical evidence of an association between the measured demographic characteristics and baseline quality-of-life categories.

In contrast, the Indian rural study involving 430 older adults reported that age, gender, educational status, marital status, economic status, and chronic disorders were associated with quality-of-life scores. Specifically, older age, lack of schooling, absence of a spouse, lower economic status, and chronic illness were independently associated with lower quality of life. The difference between the studies may be due to variations in sample size, participant characteristics, measurement approaches, and statistical methods. Therefore, the absence of statistically significant associations in the present study should not be interpreted as proof that demographic factors have no relationship with quality of life.

Overall comparison

Overall, the present study's findings are supported by evidence that comprehensive geriatric interventions can improve quality of life. Nevertheless, findings from community-based programmes show that improvements may vary across outcomes and settings. The results of the present study are encouraging, particularly because improvements were observed across physical, psychological, social, and environmental domains. If the study did not include a control group, these changes should be described as improvements observed after the programme rather than definitive proof that the programme alone caused them.

17.Conclusion:

The present study was conducted to assess the impact of a geriatric health care programme on improving the quality of life among geriatrics in a selected rural area. The findings of the study demonstrated that the participants had considerable limitations in their quality of life before the intervention. In the pre-test, 78.18% of participants had average poor quality of life and 21.82% had poor quality of life, while none had good quality of life. Following the implementation of the geriatric health care programme, a marked improvement was observed, with 66.36% achieving good quality of life and 33.64% achieving average quality of life. Significant improvements were found in the physical, psychological, social, and environmental domains, as well as in overall quality of life, with all *p*-values less than 0.001. The overall mean quality-of-life score increased substantially from 53.73 to 98.53. However, no significant association was found between pre-test quality of life and the selected demographic variables. Thus, the study concludes that the geriatric health care programme was effective in significantly improving the quality of life of older adults in the selected rural community and emphasizes the importance of structured, comprehensive, and accessible geriatric care programmes for promoting healthy ageing and overall well-being.

18.References:

- 1.Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179–211. [https://doi.org/10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T)

2. Choi, J. Y., Lee, S. H., & Yu, S. (2024). Exploring factors influencing caregiver burden: A systematic review of family caregivers of older adults with chronic illness in local communities. *Healthcare*, 12(10), Article 1002. <https://doi.org/10.3390/healthcare12101002>
3. Isac, C., Lee, P., & Arulappan, J. (2021). Older adults with chronic illness—Caregiver burden in the Asian context: A systematic review. *Patient Education and Counseling*, 104(12), 2912–2921. <https://doi.org/10.1016/j.pec.2021.04.021>
4. Whitehead, L., Jacob, E., Towell, A., Abu-Qamar, M., & Cole-Heath, A. (2018). The role of the family in supporting the self-management of chronic conditions: A qualitative systematic review. *Journal of Clinical Nursing*, 27(1–2), 22–30. <https://doi.org/10.1111/jocn.13775>
5. World Health Organization. (2020, October 26). Healthy ageing and functional ability. <https://www.who.int/news-room/questions-and-answers/item/healthy-ageing-and-functional-ability>
6. Singh A, Palaniyandi S, Palaniyandi A, Gupta V. Health related quality of life among rural elderly using WHOQOL-BREF in the most backward district of India. *J Family Med Prim Care*. 2022;11(3):1162–1168. doi: [10.4103/jfmprc.jfmprc_1073_21](https://doi.org/10.4103/jfmprc.jfmprc_1073_21).
7. Krishnappa L, Gadicherla S, Chidambaram P, Murthy NS. Quality of life (QOL) among older persons in an urban and rural area of Bangalore, South India. *J Family Med Prim Care*. 2021;10(1):272–277. doi: [10.4103/jfmprc.jfmprc_1241_20](https://doi.org/10.4103/jfmprc.jfmprc_1241_20).
8. Dongre AR, et al. Social determinants of quality of elderly life in a rural setting of India. *Indian J Palliat Care*. 2012;18(3):181–189. [Read the article](#). Verify the complete author list and pagination against the journal record before submission.
9. Von Steinbüchel N, Lischetzke T, Gurny M, Eid M. Assessing quality of life in older people: psychometric properties of the WHOQOL-BREF. *Eur J Ageing*. 2006;3(2):116–122. doi: [10.1007/s10433-006-0024-2](https://doi.org/10.1007/s10433-006-0024-2).
10. Peel NM, Bartlett HP, Marshall AL. Measuring quality of life in older people: reliability and validity of WHOQOL-OLD. *Australas J Ageing*. 2007;26(4):162–167. doi: [10.1111/j.1741-6612.2007.00249.x](https://doi.org/10.1111/j.1741-6612.2007.00249.x).
11. Psychometric properties of the Hindi version of the World Health Organization Quality of Life Questionnaire-Older Adults (WHOQOL-OLD) Module in Dehradun, India. 2023. [Read the PubMed record](#). Verify the authors, journal, volume, issue, and pages before including this reference in the final thesis bibliography.
12. Mixed methods implementation evaluation of community-based intergenerational program to improve the quality of life of the elderly in rural Maharashtra. 2026. [Read the full article](#). This study was published recently; verify its complete author list, journal details, and DOI from the publication record before final submission
13. Chen, Z., Ding, Z., Chen, C., Sun, Y., Jiang, Y., Liu, F., & Wang, S. (2021). Effectiveness of comprehensive geriatric assessment intervention on quality of life, caregiver burden and length of hospital stay: A systematic review and meta-analysis of randomised controlled trials. *BMC Geriatrics*, 21, Article 377. <https://doi.org/10.1186/s12877-021-02319-2>
14. Jakasania, A., Bhuyar, M., Bhanarkar, M., Mundra, A., Raut, A. V., Maliye, C., et al. (2026). Mixed methods implementation evaluation of community-based intergenerational program to improve the quality of life of the elderly in rural Maharashtra. *BMC Geriatrics*, 26, Article 945. <https://doi.org/10.1186/s12877-026-07550-3>
15. The WHOQOL Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), 551–558. <https://doi.org/10.1017/S0033291798006667>