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Quality of Life and Healthy Lifestyle of Ill Youth from Rural and Urban Areas

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Abstract

The paper deals with the differences between the perceived quality of life and declared lifestyle of the youth suffering from chronic diseases, the said differences being important from the point of view of both social and medical sciences. This issue has not been sufficiently analysed yet, especially, its socio-demographic aspects as a cause for health inequalities. Hence, the aim of this paper is to present the differences between urban and rural areas in respect of quality of life and health-related lifestyles.

Keywords: a sense of quality of life, health behaviors, health, chronic illness, youth

Introduction

The environment in which humans live, especially, in the periods of childhood and adolescence, can have far-reaching effects on health. The World Health Organisation (2008) pays special attention to social determinants of health defined as the conditions in which people are born, grow, work, live and age which are presented in a broader economic and political context. Within this context social determinants of health include the human beings' places of residence together with their circumstances, such as close neighbourhood characteristics, natural environment, adopted lifestyle or public policy (Cockerham, 2016). Social conditions can contribute to both the occurrence of chronic diseases, or, if appropriately modified, prevent their occurrence (Cockerham, Hamby, Oates, 2017). Additionally, the place of residence may affect changes in the perceived quality of life, in particular, in the case of chronically ill people (see:

Thomas et al., 2016) and affect their lifestyles (Bell et al., 2016; Chillón, Ortega, Ferrando, Casajus, 2011). Thus, the aim of the paper is to present the differences in the perceived quality of life and health-related lifestyles among chronically ill youth from urban and rural areas.

Quality of Life and Healthy Lifestyle as Elements of Pro-Health Lifestyle

Health-related lifestyles and the perceived quality of life have a substantial impact on the process of coping with a chronic disease situation. The perceived quality of life is of a multi-faceted structure including various spheres of human functioning. “Numerous studies confirm the existence of relationships between the quality of life indicators and health indicators, disease character, its phases, applied treatment methods, rehabilitation and existing systems of social assistance” (Wnuk, Marcinkowski, 2013, p. 274). Thus, the perceived quality of life is a “psychological construct covering physical, mental, social, psychological and behavioural aspects of well-being and functioning as perceived by patients” (Ravens-Sieberer, Bullinger, as cited in: Oleś, 2010, p. 58). At present, a healthy lifestyle is highly regarded and its promotion is an effective determinant of both health and the perceived quality of life. The World Health Organisation defines lifestyle as a “way of living based on the interplay between broadly understood conditions for life and individual patterns of behaviour determined by social and cultural factors and individual characteristics” (Kickbusch, 1986, as cited in: Misiuna, 1994, p. 101). In accordance with the above said it was assumed in this paper that a healthy lifestyle is a multi-dimensional model of voluntarily performed everyday activities and youth attitudes towards life which may have clear-cut consequences in the form of the achieved health condition (Gillis, 1997, p. 31, as cited in: Duda, 2016, p. 106).

Materials and Methods

The research problem: Are there any differences in the perceived quality of life and the lifestyle led between youth from rural and urban areas and, if yes, what are they? The general hypothesis is included in the statement that there are differences between the researched groups depending on their place of residence. To answer the research problem we used the diagnostic poll method carried out with the use of a survey technique, KIDSCREEN Perceived Quality of Life Scale depending on Health, an Adolescent Lifestyle Questionnaire (ALQ) by A. Gillis (1997) (experimental version) and particulars. The Student’s t-test was used for verification of the hypothesis.

The study involved 403 students aged 16–19 suffering from chronic health problems. Girls accounted for 52.3% of the group. The group of boys contained 192 individuals. All the participants had chronic diseases. In the majority of

cases they lasted from several weeks to several years (81.1%) but in 76 persons they were congenital diseases. The place of residence being the analysed variable divided the group into two sub-groups: village dwellers (233 persons), who constituted the majority of the people surveyed, and town dwellers (170 persons). The criterion of the place of residence was understood as a place where the person physically lived and grew.

Analysis and Discussion of Results

In the case of chronically ill youth no significant differences have been found between students living in rural and urban areas as regards the perceived health-related quality of life. The only dimension which differed significantly among the survey participants concerned physical health. The result indicates that young people from rural areas are characterised by significantly better physical health despite illness-related limitations.

Table 1. Comparison of mean outcomes regarding the perceived quality of life depending on health of ill students by their place of residence obtained with the use of the KIDSCREEN-52 scale; *p < 0.05

Dimensions of health-related quality of life	Town (N=170)		Village (N=233)		t-test		
	M	SD	M	SD	t	df	p
Physical well-being	10.51	3.53	11.36	3.57	2.385	401	0.018*
Psychologic well-being	13.42	5.18	13.48	4.68	0.136	401	0.892
Mood and emotions	17.34	5.19	17.26	5.15	-0.152	401	0.879
Self perception	11.18	3.90	11.60	3.97	1.068	401	0.286
Autonomy	12.07	4.03	11.61	4.23	-1.093	401	0.275
Parent relations and home life	14.86	5.25	14.94	5.02	0.137	401	0.891
Financial resources	6.25	3.08	6.53	2.76	0.959	401	0.338
Social support	14.38	5.12	14.61	4.71	0.464	401	0.643
School environment	10.42	4.42	9.99	4.17	-1.011	401	0.313
Social acceptance	9.98	2.43	9.81	2.39	-0.723	401	0.470
TOTAL (global result)	120.41	25.77	121.18	26.12	0.297	401	0.766

In the case of surveyed youth there are no statistically significant differences as regards the healthy lifestyle between students coming from urban and rural areas. The arithmetic means and standard deviations for the groups compared by the variable being a place of residence and difference test values are presented in Table 2.

Table 2. Comparison of mean outcomes for healthy lifestyles of ill students by the place of residence obtained with the use of the Adolescent Lifestyle Questionnaire (ALQ);

***p < 0.05**

Lifestyle dimensions	Town (N=170)		Village (N=233)		t-test		
	M	SD	M	SD	t	df	p
Physical participation	12.88	4.10	13.42	3.83	1.379	401	0.169
Nutrition	23.09	7.88	22.97	6.14	-0.169	401	0.866
Social support	27.31	4.95	27.23	5.01	-0.162	400	0.871
Stress management	34.79	2.44	34.93	2.41	0.561	401	0.575
Identity awareness	32.59	6.99	32.68	6.25	0.139	400	0.889
General health practices awareness	9.55	3.59	9.85	3.49	0.838	401	0.403
Safety	27.33	5.80	26.84	5.44	-0.864	400	0.388

The results presented indicate that the current place of residence does not significantly differentiate either the quality of life standards of the youth or their lifestyles. In the case of the perceived quality of life, young people living in rural areas revealed a slightly higher level of it which was also confirmed in the study by Chillón and co-workers (2011). Perhaps “civilisation advancement of the countryside creates better conditions for the development of youth and adolescents” (Wilczewski, 2012, p. 6). Health practices in both groups were similar but urban youth are characterised by lower levels of physical activity which implies a higher risk of civilisation diseases, e.g. obesity, which was also noted by Hoffman in her studies (2011; see: Suder, Janusz, Jagielski, Głodzik, Pałka, Cison, Pilch, 2015).

Conclusions

The results presented in this paper indicate that there are no significant differences between the researched groups of students with health problems. Perhaps the only significant variable which has not been examined in this study is the financial situation which is also a component of the concept of social determinants of health. The obtained results indicate the need to monitor both the sense of quality of life and the lifestyle with additional socio-economic variables. Hence, further research into contemporary determinants of chronic diseases should focus more on the economic aspect.

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