

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

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Highlights: (1) the prevalence of low quality of life in the elderly population in rural areas was 47.7%. (2) younger age, religion, ownership of private transport and use of the internet and public services were associated with a lower probability of having a perception of low quality of life. (3) Depressive symptoms and housing that was not constructed as a single block were associated with low quality of life.

PRE-PROOF

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ABSTRACT

Objective: To analyze the factors associated with the quality of life of elderly people living in a rural area. **Method:** This cross-sectional and analytical study was conducted using a questionnaire that analyzed sociodemographic aspects, living conditions, and health, in addition to the instrument...WHOQOL-OLD, used to assess quality of life of elderly people. Data collection took place in Basic Health Units from the rural area of the municipality of Guanambi, Bahia, Brazil, between March and September 2025. A Low quality of life was defined as the dependent variable (reference category). For the multiple analysis, Poisson regression with robust variance was used. **Results:** The study included 111 participants. Of these, 47.7% have low quality of life. In the final model, those categorized as users of public services (PR=0.46) and internet services (PR=0.52), with their own transportation to the Basic Health Unit (PR=0.67), who had some type of religion (PR=0.38), and the youngest (RP=0.96) were less likely to exhibit a Perception of low quality of life. However, participants who had depressive symptoms (PR=2.19) and lived in housing not built in blocks (PR=1.46) were more likely to have a low quality of life. **Conclusion:** There is a higher prevalence of low quality of life among older adults who were older, had depressive symptoms, did not use the internet, did not frequent public health services, did not have their own transportation or religion, and lived in housing not built in blocks. Therefore, it is necessary to promote actions aimed at improving mental health, expanding the availability of care in health units, and improving social conditions, considering the age-specific characteristics of this population residing in rural areas.

Keywords: Social Conditions; Depression; Elderly; Quality of Life; Health Services; Rural Area.

Introduction

In Brazil, the elderly population, composed of individuals aged 60 (sixty) years or older¹, is growing rapidly amidst profound social, economic, and regional inequalities. This scenario directly interferes with how these individuals experience aging and perceive their quality of life, especially when considering sociodemographic factors, self-perception of health, and living conditions².

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

Quality of life is defined as an individual's perception of their position in life, within the context of the culture and value systems in which they are embedded, as well as in relation to their goals, expectations, standards, and concerns. It is, therefore, a broad, dynamic, and multidimensional concept that involves physical, psychological, social, economic, and environmental aspects, reflecting the overall well-being of human beings³.

With regard to the elderly, quality of life is influenced by multiple factors that intertwine in the aging process, especially those associated with health conditions, income, type of housing, access to health services, habits and lifestyles⁴. There is also interference from the environmental context and the living conditions in which the individual is embedded⁵, therefore, there are differences between rural and urban areas.

The Brazilian rural area is defined as all space located outside the urban perimeter, legally established by the municipal governments, which has a dispersion of dwellings, a predominance of the primary sector, especially agricultural production, and lower population density.⁶

Considering this environmental context, the quality of life in old age in urban areas tends to show better scores related to access to health services, the availability of social facilities, leisure options, and opportunities for social participation, even though these people are exposed to higher levels of stress, insecurity, and social isolation.⁷

On the other hand, in rural areas, although structural limitations, lack of public transport, lower income and difficulties in accessing specialized health services persist, there is greater community ties and social interaction, frequent contact with nature and a greater sense of belonging, aspects that may favor a more positive perception of quality of life.⁸ Thus, the reality of these populations requires special attention, since rural territories concentrate high rates of inequality and limitations in access to public policies, health services and leisure opportunities.

Despite the progress in discussions on the subject, scientific production is still unevenly explored, with a greater concentration of studies in urban contexts,⁹ while aging in rural areas of Brazil remains less investigated, especially with regard to territorial and social specificities and access to health services.

Analyzing the factors associated with quality of life in older adults living in rural areas is an important tool for understanding the multiple dimensions of aging, supporting the

development of nursing care practices and intersectoral actions aimed at promoting autonomy, social inclusion, and well-being. Given this context, the objective of this study was to analyze the factors associated with the quality of life of older adults living in a rural area.

Methodology

This is a quantitative study. This cross-sectional and analytical study was guided by the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool. This research is part of an umbrella project entitled "Health conditions of adults and older people: a prospective study".

Eligible participants for the study were individuals aged 60 years or older, registered at one of the four Basic Health Units (UBS) in the rural area of the municipality of Guanambi, Bahia, Brazil, who presented preserved cognitive function and independence in performing basic activities of daily living. These last two criteria were certified by the teams of the respective UBS. Elderly individuals without severe alterations in speech, vision, or hearing, identified by the researchers during the data collection phase, were also included to avoid compromising the interviews.

According to the records provided by the four primary health care unit (UBS) teams, there were 1,382 elderly people in their respective territories who met the eligibility criteria. Based on this reference, the sample size calculation was applied considering the following data: 95% confidence interval (95% CI), 5% sampling error, and an estimated prevalence of 50%. To the obtained sample size, a percentage of 10% was added to compensate for probable losses. Thus, a final sample of 331 volunteers was projected.

During the data collection period, which took place between March and September 2025, 177 elderly individuals were located, but 66 refused to participate in the research due to unavailability to remain longer at the primary health care unit ($n = 42$), the need to acquire transportation to return home and perform household or work tasks ($n = 13$), as well as the fear that the care provided at the primary health care unit would not be completed ($n = 7$). Furthermore, other individuals did not specify the reason for their refusal ($n = 4$). Thus, the final sample consisted of 111 participants.

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

The nurses at the primary health care units (UBS) provided a list of elderly people who met the eligibility criteria. Using these names, the researchers compiled a nominal list for each UBS. For the selection of the non-probabilistic sample, the convenience sampling criterion was adopted, considering the difficulty of applying the research to the projected sample. This decision is justified by the fact that... The population in these rural areas commonly stays at the primary health care units for a short period of time due to the need to return to daily activities during the day, as well as the availability of rooms in the health units, during all data collection shifts, to conduct the research in a quiet, safe, and comfortable environment for the participants.

All elderly individuals who attended the primary health care units (UBS) on the days of data collection were invited to participate in the study, both before and after their appointments. For those who agreed to participate, the instruments were administered after they signed the Informed Consent Form. In order to avoid bias in data collection, nursing graduates were previously trained and instructed by the study coordinator.

The following data collection instruments were used: (i) sociodemographic, economic and health conditions questionnaire and (ii) Scale of Geriatric Depression (GDS), which does not have a diagnostic purpose, but allows measuring the presence of depressive symptoms in elderly people without cognitive decline. This instrument showed validity and reliability (Cronbach's alpha: 0.94 suitable in Brazilian territory. In the present study, the reduced version of the scale was used, composed of 15 items, with scores ranging from zero to one point per item. The total score ranges from zero to 15 points, and can be categorized as absence of depressive symptoms (up to five points) and indicative of depressive symptoms (six points or more)¹⁰; and (iii) the WHOQOL-OLD instrument, used to assess quality of life in older people.

The WHOQOL-OLD has been validated for the Brazilian population, showing adequate internal consistency, with Cronbach's alpha ranging from 0.71 to 0.88. The questionnaire consists of 24 items, assessed on a five-point Likert scale (1 to 5), distributed across six facets or domains: sensory functioning; autonomy; past, present, and future activities; social participation; death and dying; and intimacy. The values of the 24 items can be combined to compose an overall WHOQOL-OLD score (QVG-OLD), which ranges from

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

0 to 100 points. Higher scores indicate better quality of life, while lower scores indicate poorer quality of life¹¹.

Quality of life does not have a defined and standardized cutoff point; therefore, the median was used for its dichotomization into low and high quality of life. Thus, the dependent variable was defined as low quality of life.

The independent variables in this study were divided into thematic blocks, namely:

- Sociodemographic and economic variables: sex (male; female); age (numerical variable, in years); marital status (without partner; with partner); education (in years of study: up to three; four or more); self-declared race/skin color (black, including black and brown; non-black, including white, yellow and indigenous); type of transport (own; other, including public transport, municipal vehicle and use of animal); type of housing (block; other, including masonry and adobe); internet use (no; yes); has a religion (no; yes); and cohabitation (lives alone: no; yes).
- Health issues: use of public health services (no; yes); morbidity (number of self-reported chronic diseases); depressive symptoms (no depressive symptoms; with depressive symptoms), assessed by the GDS.

The data were organized, inspected by two data entry operators, and analyzed using the Statistical Package for the Social Sciences (SPSS), version 21.0. Categorical variables were described using absolute (n) and relative (%) frequencies, while numerical variables were presented using measures of central tendency (mean and median) and dispersion (standard deviation). Bivariate analyses were performed using the chi-square and Student's t-tests. At this stage, variables with a descriptive level of less than or equal to 20% ($p \leq 0.20$) were selected to initially compose the multiple model, adopting Poisson regression with robust variance, using the enter12 method.

All variables that presented $p \leq 0.20$ were simultaneously included in the model, and subsequently removed one by one, keeping in the final model only the variables that presented a significance level of 5% ($p < 0.05$). Prevalence ratios (PR) were estimated, with respective 95% confidence intervals and a 5% confidence level. The goodness of fit of the model was assessed using the significance of the Omnibus test and the standard deviation¹².

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

The study was submitted to and approved by the Committee of Ethics in Research at the State University of Bahia, under substantiated opinion no. 7,308,879, in accordance with Resolutions no. 466/2012 and no. 510/2016 of the National Health Council.

Results

The study included 111 participants. From a sociodemographic perspective, there was a predominance of younger elderly individuals, female, in stable relationships, with low levels of education, self-identifying as Black, practicing religion, cohabiting with others in the same household, attending the Basic Health Unit, and using their own means of transportation. Furthermore, most resided in houses built in blocks and used the internet. Regarding health conditions, the sample generally presented at least two morbidities; however, depressive symptoms were not observed in most participants. Concerning quality of life, a prevalence of 47.7% of low quality of life (dependent variable) was found, with a median of 77.1 and a standard deviation of 9.7. These data are presented in Table 1.

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

Table 1. Demographic variables, housing and transportation conditions, and use of public health services associated with the quality of life of elderly people living in rural areas. Guanambi, Bahia, 2025 (n=111).

Variable		p-value
Age¶	67.9 ± 6.5	0.110**
Sex§		0.380
Feminine	58 (52.3%)	
Masculine	53 (47.7%)	
Marital status		0.040*
Without a partner	26 (23.4%)	
With companion	85 (76.6%)	
Education		0.679
Up to 3 years of study	79 (72.5%)	
≥ 4 years of study	30 (27.5%)	
Race/skin color		0.241
Black people (black/brown)	87 (78.4%)	
Non-black (white)	24 (21.6%)	
Does he/she have a religion?		0.102**
No	3 (2.7%)	
Yes	107 (97.3%)	
Lives alone§		0.102**
No	105 (94.6%)	
Yes	6 (5.4%)	
Type of transport§		0.060**
own motor vehicle	83 (74.8%)	
Other (public transport vehicle/municipal vehicle/use of animals)	27 (24.5%)	
Use of public services		0.027*
No	8 (7.2%)	
Yes	103 (92.8%)	
Type of housing§		0.153**
Block	69 (62.7%)	
Other (masonry and adobe)	41 (37.3%)	
Internet use		0.023*
No	11 (10.0%)	
Yes	99 (90.0%)	
Depressive symptom		0.013*
Absent	102 (91.9%)	
Present	9 (8.1%)	
Morbidity	1.9±1.2	0.008*

¶Student's t-test; chi-square test; mean and standard deviation; absolute (n) and relative (%) frequency; *p<0.05;

**p<0.20

Source: prepared by the authors.

Table 2 presents crude and adjusted analyses of the association between low quality of life and independent variables. Variables with $p < 0.20$ were incorporated into the model, namely: age, marital status, internet and public health service use, cohabitation, type of housing, type of transportation, depressive symptoms, and morbidity. It was observed that older people who frequently used health services (PR = 0.46; 95% CI: 0.30–0.70), used the internet (PR = 0.52; 95% CI: 0.33–0.81), used their own transportation (PR = 0.67; 95% CI: 0.46–0.98), had a religion (PR = 0.38; 95% CI: 0.22–0.64), and were younger (PR = 0.96;

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

95% CI: 0.92–0.99) were less likely to have low quality of life compared to people who did not use health services, did not access the internet, used other means of transportation, did not have a religion, and were older..

Conversely, a higher prevalence of low quality of life was observed among older adults with depressive symptoms (PR = 2.19; 95% CI: 1.44–3.32) and among those residing in non-block-built housing (PR = 1.46; 95% CI: 1.02–2.09), when compared to individuals without depressive symptoms and those residing in block-built houses. These findings indicate that alterations in mental health and inadequate housing conditions are associated with a greater likelihood of poorer perceived quality of life (Table 2).

Table 2. Crude and adjusted prevalence ratio of independent variables according to low quality of life in elderly people residing in rural areas. Guanambi, Bahia, 2025 (n = 111).

Variables	RP*cruta (CI 95%)	p-value	Adjusted RP* (95% CI)†	p-value
Marital status		0.457		
Without a partner	1		-	-
With companion	0.84 (0.53 – 1.33)		-	
Depressive symptoms		0.002		<0.001
No depressive symptoms	1		1	
With depressive symptoms	2.06 (1.30 - 3.26)		2.19 (1.44 – 3.32)	
Internet usage		0.002		0.004
No	1		1	
Yes	0.51 (0.33 – 0.78)		0.52 (0.33 – 0.81)	
Use of public services		0.000		<0.001
No	1		1	
Yes	0.42 (0.25 – 0.68)		0.46 (0.30 – 0.70)	
Type of transport		0.055		0.042
Other (public transport vehicle/municipal vehicle/use of animals)	1		1	
own motor vehicle	0.69 (0.47 – 1.01)		0.67 (0.46 – 0.98)	
Type of housing		0.029		0.038
Block	1		1	
Other (masonry and adobe)	1.47 (1.04 – 2.06)		1.46 (1.02 – 2.09)	
Does he/she have a religion?		0.000		<0.001
No	1		1	
Yes	0.32 (0.18 – 0.59)		0.38 (0.22 – 0.64)	
Lives alone		0.526		
No	1		-	-
Yes	1.24 (0.64 – 2.38)		-	
Age	0.96 (0.92 - 0.99)	0.037	0.96 (0.92 – 0.99)	0.030
Morbidity	1.09 (0.91 - 1.29)	0.354	-	-

*RP: prevalence ratio; †95% CI – 95% confidence interval; standard deviation: 0.605.

Source: prepared by the authors.

Discussion

This study identified that 47.7% of participants had a perception of low quality of life. The results showed that sociodemographic characteristics, health conditions, use of public services and the internet, as well as the type of housing and means of transport, are associated with the quality of life of elderly people living in the rural areas surveyed.

The participants' quality of life showed a median of 77.1 ± 9.7 , a result higher than that found in studies conducted in urban contexts, both internationally,¹³ as well as national ones¹⁴. Better quality of life in rural contexts can occur due to local specificities, such as stronger community ties, closer social relationships, frequent contact with nature, and a less accelerated pace of life, factors that can favor a more positive perception of quality of life, despite the structural limitations often attributed to these territories^{5,8}.

In line with the issues raised, the participants in this study have preserved cognitive and physical functions and, despite the limitations of age, still engage in leisure activities, work, and other activities related to basic care of their living environment. The development of these productive activities can give meaning to these people's lives and promote their well-being, reflecting in a better perception of their quality of life.

Previous studies have shown that the presence of depressive symptoms is associated with a decline in quality of life in older adults, with negative impacts on physical, psychological, and social domains.^{15,16} In rural contexts, this association tends to be intensified, since elderly people residing in these areas may face greater vulnerabilities, such as difficulties in accessing health services, especially mental health care, and a higher risk of social isolation. These factors contribute to the worsening of depressive symptoms and a more negative perception of quality of life.^{17,18}

The manifestation of depressive symptoms compromises autonomy, reduces social participation, and intensifies feelings of isolation, factors that directly affect the perception of well-being in this population. These effects directly impact various aspects, contributing to a more unsatisfactory and less meaningful perception of life.^{18,19} Therefore, it is necessary to expand the availability of treatment to reduce the harm caused by this condition and to offer continuous actions for prevention and promotion of mental health focused on health education. Furthermore, interventions addressing the causes of this illness are also fundamental to confronting the origin of these negative emotional symptoms.

FACTORS ASSOCIATED WITH THE QUALITY OF LIFE OF ELDERLY PEOPLE IN RURAL AREAS

As in other studies^{20,21}, religious practice was associated with a better perception of quality of life among participants. Spirituality/religiosity contributes to the construction of meaning in the face of losses and challenges of aging, acting as a coping resource capable of reducing depressive and distressing symptoms, as well as promoting psychological well-being.²² Furthermore, beliefs, values, and involvement in religious communities provide social support, feelings of belonging, and hope, fundamental elements for maintaining mental health and psychosocial autonomy in old age, reflecting in better quality of life indicators.²³

Corroborating previous research^{9,24} Age showed an inverse relationship with quality of life, indicating that younger elderly people had a better quality of life compared to older people. Advancing age tends to be accompanied by a reduction in cognitive, functional, and social abilities, as well as an increase in morbidities and factors such as social isolation and the presence of negative feelings, which negatively influence the quality of life of older people. This impact is more pronounced among older people, who, compared to younger people, exhibit these conditions more significantly¹⁴.

This study showed that internet use positively influenced the perception of quality of life in old age. Digital inclusion among older people, although still marked by inequalities related to education, income, and access to technologies, has been associated with strengthening autonomy, expanding social support, and maintaining social participation. Access to digital tools favors communication with family members and support networks, enables greater access to health information, and contributes to reducing social isolation, factors that directly impact the psychological and social domains of quality of life. Recent studies have demonstrated that digital engagement in old age is related to achieving better mental health indicators, a greater perception of independence, and a sense of social belonging^{25,26}.

A high percentage of participants reported using health services (92.8%) and owning their own vehicle to travel to the Basic Health Unit (74.8%), both of which factors are associated with a better perception of quality of life. The availability and regularity of access to health services, combined with autonomy in travel, favor continuous monitoring, prevention of complications, and proper management of chronic conditions, which are

central aspects for the well-being of elderly people living in rural areas, especially in the physical and psychological domains^{27,28}.

The presence of primary health care units in rural areas promotes better overall living and health conditions for vulnerable populations and increases the sense of valuing human needs, historically neglected in communities embedded in unfavorable socioeconomic and cultural contexts. For elderly people without their own transportation, home visits, through active outreach, and telehealth services can represent viable alternatives to reduce inequalities and improve health monitoring.

Therefore, it is necessary to invest in improving internet connectivity to enable online consultations, in paving roads, and in allocating automotive resources to transport healthcare teams to homes left without access due to these inequalities. Furthermore, investment in professional development is essential for achieving successful results.

Most of the elderly people in the present study lived in houses built of concrete blocks (62.7%), suggesting better structural housing conditions in the investigated territory, even in a context marked by socioeconomic limitations. This finding differs from another study also carried out in a rural area, in which housing built with more precarious materials, such as wattle and daub, wood or improvised structures, predominates, frequently associated with structural poverty and social exclusion of these people²⁹. Inadequate housing conditions – such as structural fragility, lack of basic sanitation and difficulty in adapting the home – are directly related to worse health outcomes, greater functional dependence and lower perception of quality of life among elderly people living in rural areas³⁰.

Adequate housing is one of the pillars of healthy aging, especially in rural contexts, where economic inequalities and barriers to access to public policies tend to intensify social and health vulnerabilities.³¹ Thus, the presence of homes with better built standards in the studied territory can act as a protective factor, reducing the risk of domestic accidents, promoting functional autonomy, and fostering greater comfort and safety, positively impacting the quality of life and the elderly person's ability to remain in their home with dignity and independence.

Among the study's limitations, the impossibility of inferring causality stands out, given the cross-sectional design. Furthermore, the research was conducted with a convenience sample, which limited population coverage, meaning that the generalization of

the results should be interpreted with caution due to the non-randomness of the participants. Despite these limitations, the study was conducted using the STROBE tool, which confers methodological rigor. Finally, the investigation focused on a vulnerable population, such as elderly people residing in rural areas, contributes to the understanding of quality of life in contexts that are still underrepresented in the national literature.

Conclusion

It was verifiedA prevalence of low quality of life was found in 47.7% of the participants in this study. People who used public services and the internet, who had their own transportation to get to the primary health care unit, who had some type of religious affiliation, and who were younger were less likely to present low quality of life. Conversely, participants with depressive symptoms and who lived in houses that were not built of masonry presented higher prevalence.or probability of low quality of life.

This scenario points to the need to strengthen public and intersectoral policies aimed at the rural elderly population, with an emphasis on the positive impact on health. To this end, it is suggested that access to health services be expanded and home care services be offered to these individuals.elderly women, conducting active searches to identify those who do not adhere to the guidelines.pontanThis is particularly relevant to the health programs of the primary health care units, as well as improving connectivity through the installation of internet towers. Furthermore, it is recommended to pave roads and implement community transportation strategies to facilitate travel, expand government community support programs aimed at improving housing infrastructure, and train primary health care professionals to work in this area, especially regarding the promotion of mental health among this population.

Future research with multiple approaches may be useful in filling existing gaps. Longitudinal studies can establish clearer and more objective relationships between factors associated with quality of life. Qualitative investigations can help in the subjective understanding of the interactions between these variables and how they affect the lives of these people. The combination of these studies may provide a basis for...more effective interventional research aimed at promoting overall improvements in the perception of quality of life.of this group.

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