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Quality of Life for Elderly People with Cardiovascular Diseases

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The Council of College of Nursing, University of Babylon in Partial Fulfillment of the Requirements for the Degree of Master in Nursing Sciences

By

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بسم الله الرحمن الرحيم

إِمَّا يَبْلُغَنَّ عِندَكَ الكِبَرَ أَحَدُهُمَا أَوْ كِلاهُمَا فَلا تَقُل لَّهُمَا أُفٍّ ولا تَنْهَرْهُمَا وقُل لَّهُمَا قَوْلاً كَرِيماً

صدق اللَّهُ الْعَظِيمُ

سورة الإسراء - الآية 23

Dedication

To the soul of my father who taught me the meaning of life.

****

To the pure spirit who gave me her blood, soul and love ……..my lovely Mother

****

To my wife and lovely children Ameer and Zainab who bring the joy to my life

****

To my brothers and friends with my love and Respect

****

Baha Kareem 2022

Supervisor certificate

I certify that this thesis, entitled ***(Quality of Life for Elderly people with Cardiovascular Diseases)*** submitted by **Baha Kareem jawad** and prepared under my supervision and guidance at the Department of Family &Community health Nursing, Faculty of Nursing, University of Babylon as a partial fulfillment of requirements for the Degree of Master Sciences in Nursing.

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abstract

Background: Despite the significant advances in prevention, diagnosis, treatment, and rehabilitation, cardiovascular disease remains one of the most common chronic diseases. According to statistics, cardiovascular disease is the leading cause of death worldwide. Many factors, including heredity, lifestyle, avoiding smoking, and physical activity, can affect the elderly's quality of life. Lower health related quality of has been linked to an increased risk of hospital readmission and mortality in patients with cardiovascular diseases such as heart failure or ischemic heart disease, as well as Cardiovascular diseases mortality in a variety of society samples. **Objective**s: The study aims to assess the Quality of Life of Elderly People with Cardiovascular Diseases .To find out the relationship between socio-demographic data characteristics of the for Elderly people with cardiovascular diseases and quality of life. **Methods:** A descriptive study design is used for a period between 1st October 2022 to the 15 of May 2022; the study was conducted in Al-Hilla City in Babylon province. Purposive (non-probability) sample from 120 patients selected of both genders of elderly age, who medically diagnosed with cardiovascular diseases visited hospital and outpatient department for consultations. Modified questionnaire used to collect data from patients and take into consideration inclusion and exclusion criteria. analyzed electronically by using the SPSS program Version 26. **Results:** The majority of patients ages (72%) ranged from 60-69 years. In regard to gender, most of the studied sample was female. The medical history of the sample revealed most people had a history of coronary artery disease and the duration of the disease by recorded more than 2 years with the disease. The majority of Study sample were elderly people with cardiovascular conditions who did

not have any other chronic diseases. The finding exhibited a Moderate Quality of life for elderly people with cardiovascular diseases. **Conclusions and Recommendations:** The study concludes that general health, physical health, environmental health was the most common associated with poor quality of life, the psychological health have moderate mean score and social health records the highest mean score as a good quality related to social health. There is significant relationship among the quality of life and their age groups, employment, economic status and residency of elderly persons. Recommended develop educational programs can encourage a healthy body weight, regular physical activities to improve patient life adaptability, and psycho-social support.

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List of Abbreviations

1.	**AHA**	American heart association
2.	**ANOVA**	Analysis of variance
3.	**BMI**	Body mass Index
4.	**CHD**	Chronic heart diseases
5.	**CVD**	Cardiovascular diseases
6.	**CVH**	Cardiovascular health
7.	**DM**	Diabetic mellites
8.	**GCC**	Gulf Cooperation Council
9.	**H. S**	Highly significant
10.	**HF**	heart failure
11.	**HRQoL**	Health-related quality of life
12.	**LDL**	low-density lipoprotein
13.	**NCDs**	Noncommunicable Diseases
14.	**NS:**	No significant
15.	**QOL**	quality of life
16.	**SD**	Standard Deviation
17.	**SES**	social-economic state
18.	**Sig**	Significant
19.	**TC**	total cholesterol
20.	**US**	United state
21.	**WHO**	World Health Organization
22.	***M.S***	Mean of scores

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A.3	The ethical committee of the Department of Community &Family Nursing in Babylon University / College of Nursing.
B.	The study instrument (Questionnaire)
C.	Panel of Experts
D.	Linguistic approval

Chapter One

Introduction

Chapter One

Introduction

1.1 . Introduction

Understanding illness and their indications matters for two main reasons. the disease can shorten one's life expectancy, those who are afflicted with certain disorders may die young. Second, illnesses can create dysfunction as well as symptoms that impair an individual's ability to execute everyday tasks. Clinical investigations regularly use the terms mortality (death) and morbidity (dysfunction), as well as symptoms, to describe health outcomes (Kaplan & Ries, 2007).

Noncommunicable illnesses account for over two-thirds of all mortality worldwide, accounting for around 36 million deaths in 2010. The World Health Organization (WHO) identified Noncommunicable Diseases (NCDs) as one of the major concerns of the twenty-first century in 2014. NCDs are medical disorders that are not caused by infectious pathogens and can be caused by genetic or behavioral factors. In some WHO reported that in some Eastern Mediterranean Region countries, the four major non-communicable disease groups were (cardiovascular diseases, malignancies, chronic respiratory disorders, and diabetes) which account approximately 60% of mortality. The burden of non-communicable diseases will have a negative impact on socio-economic progress (Shahwan et al., 2019).

Despite considerable advancements in prevention, diagnosis, management, cardiovascular disease continues to be among the most common chronic diseases. According to report , CVD is the most cause of mortality worldwide (Kurucová et al., 2014).

according to the latest WHO data published in 2020 Coronary Heart Disease Deaths in Iraq reached 36,594 or 24.98% of total deaths. The age adjusted Death Rate is 227.26 per 100,000 of population ranks Iraq #23 in the world(WHO ,2020).

A World health organization report claims, that more than 600 million elderly people live in various countries around the world. Furthermore, it is expected that this rate will more than double by 2025, possibly reaching 2 billion by 2050. Because of numerous changes in social, economic, cultural, and demographic characteristics, the number of these elderly people continues to rise. According to the Ministry of Health's annual statistical report, the proportion of individuals over 60 years old in Iraq has increased from (3.4 percent) in 2010 to (5 percent) in 2015 and is expected to reach 7.2 percent in 2050. It places an additional burden on healthcare institutions and society by identifying those who are most vulnerable to negative effects (Abdul et al., 2020).

Health-related quality of life refers to an individual's growing knowledge of the impact of their health status on their overall functioning and well-being, which includes physical, psychological, emotional, and social functioning dimensions. Health-related quality of life is regarded as a vital patient-reported outcome measurement for all chronic disease's intervention strategies and therapies. In patients with CVD such as heart failure or ischemic heart disease, lower HRQoL has been related to an increased risk of hospital readmission and mortality (Phyo et al., 2021).

The inclusion of QOL as a health indication of outcome is attributed to the sensitivity of this measure for evaluating patients' health status after treatment and its health outcome; where the evaluation It is critical to consider the life quality because this evaluation can determine the aspects

that are significant for patients' quality of life because of the ultimate goal for treating chronic non-curable diseases. The value of QOL is vital for determining what is essential to a person's QOL because the primary goal of non-curative sickness is to improve QOL (Shaker & Nasir, 2013)

As a consequence of the global CVD burden and the aging of the population. Many factors, including heredity, lifestyle, avoiding smoking, and physical activity, can affect the elderly's quality of life and stress, chronic metabolic disorders, in particular, are some of the factors that can contribute to a decline in the elderly's life quality (Phyo et al., 2021).

1.2 Importance of the Study.

Quality of life assessment is vital indication for for improving client symptom relief, caring, and recovery. Problems identified by individuals' self-reported QOL can result in modifications and improvements in therapies and care, or they may reveal that certain therapies are unsuccessful. QOL is also used to identify the many obstacles that patients may confront. This sort of information might be presented to future patients to assist them forecast and understanding the consequences of their disease and treatment (Haraldstad et al., 2019).

Health -related quality of life indicators were found to be substantial predictors of both long and short mortality, strengthening their use in health surveillance and as risk variables for targeted preventative initiatives (Brown et al., 2015).

Knowing how healthcare procedures affect patients' lifestyles rather than simply their bodies. This is especially critical for persons with symptomatic, debilitating, or life-threatening illnesses who have little hope of a cure and have disorders that will affect their physical, mental and

social well-being. Care providers must comprehend the understanding of the concept of QOL and avoid conflating it with functional ability, symptoms, disease processes, or therapeutic side effects (Addington-Hall & Kalra, 2001).

Lower mortality risk was connected with a higher quality of life. Furthermore, encourage caregivers to implement QoL measures into regular health data gathering, which could lead to the beginning of early primary health treatment for people at high risk of early death. Furthermore, provides evidence of physical HRQoL's prognostic capacity for the threat of dying (Phyo et al., 2020).

Patients with CVD who have lost a healthy life due to impairment may have a lower QOL. Various physical and mental symptoms associated with CVD, such as dyspnea, fatigue, edema, difficulty sleeping, sadness, and chest discomfort, may impair everyday activities. High hospitalization and mortality rates are linked to poor life quality. As a result, the QOL of patients with CVD should be measured a systematically to determine its influence on their everyday lives (Komalasari et al., 2019)

Many elements of patients' quality of life may be impacted during the clinical course of CHD, including symptoms of angina and heart failure, decreased exercise capacity due to the previous symptoms, physical sickness caused, and mental trauma linked with psychological stress. The goal of modern treatments is to enhance not only life span, symptoms, and functional ability, but also life quality. As a result, an increase in HRQL is seen as an essential factor in deciding therapeutic value. It is crucial when analyzing HRQL that the instrument used assesses the health factors relevant to that particular patient group (Thompson & Yu, 2003).

The discovery of risk factors associated with CVD was one of the most important discoveries in cardiovascular research of the twentieth century, with subsequent medicines developed and rigorously tested to change these risk variables to avoid CVD. The Inter heart research examines over 27,000 cases and regulations from 52 countries and discovered that nine possibly main risk factors can explain over 90% of the social risk for cardiovascular problems: A and B apolipoprotein disorder, lifestyle , diabetes, high blood pressure, obesity, psychological stressors, nutrition, exercise, and alcohol drinking. thus, it is reasonable to believe that modifiable risk factors exist Furthermore, despite advances in CVD primary and secondary prevention, there are still a variety of socioeconomic challenges in cardiovascular health care that vary by location and time (Kreatsoulas & Anand, 2010).

Whereas the damaging effects of CVD and vascular disease on cognition in elderly people are well established, it is somewhat less well understood that CVD risk factors can be linked with essentially debilitating changes in mental function. Though these patients typically do not meet current dementia diagnostic criteria, they do suffer from cognitive ability disorders that are functionally significant enough to impair their compliance with the medical procedures taken to prevent the causal risk factors. Carrying a single CVD risk factor can cause morphometric changes in brain structures that can lead to more serious conditions such as cerebrovascular disease, cognitive impairment, and dementia if left untreated (Leritz et al., 2011).

There are three reasons why the researcher emphasizes the important of the assessment of the person's life quality with cardiovascular diseases: (1) to assess the adequacy of recovery requirements;(2) To assess the effect of

therapeutic strategies (3) To prove that this tool is vital to show management response.

1.3 . Statement of Problem

Quality of Life for Elderly People with Cardiovascular diseases

1.4 The Objectives of the Study

1. To assess the Quality of Life for Elderly People with Cardiovascular Diseases

2. To find out the relationship between socio-demographic data for Elderly people with cardiovascular diseases and quality of life

1.5 . Definition of Terms

1. A: Quality of life

A. Theoretical definition: The patient's ability to enjoy normal life activities, Qol is important consideration in medical care. (World Health Organization WHO,2014)

B: Operational definition: ability of Cardiovascular patients to act life satisfaction, including everything from physical health, family, education, employment, wealth, safety, security to freedom, religious beliefs, and the environment.

2. Elderly people

A. Theoretical definition: An older person is defined by the United Nations as a person who is over 60 years of age. However, families and communities often use other socio-cultural referents to define age, including family status (grandparents), physical appearance, or age-related health conditions.

2. operational definition: The concept of the aged population is diverse and typically includes factors like chronology, social role transition, and competence change. When investigating certain areas of clinical practice, whether the concept of an aged person is consistent, or whether it is variable and imprecise in evaluating the current body of evidence.

3.Cardiovascular Diseases

A: Theoretical definition: Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. It's usually associated with a build-up of fatty deposits inside the arteries (atherosclerosis) and an increased risk of blood clots. It can also be associated with damage to arteries in organs such as the brain, heart, kidneys and eyes.(E et al., 2022)

B. Operational definition: group of disorders of the heart and blood vessels occur prematurely in people in old age and include coronary heart disease, cerebrovascular disease, rheumatic heart disease and other conditions. More than four out of five CVD deaths are due to heart attacks and strokes, and one third of these deaths

Chapter Two

Review of literature

Chapter Two

Review of Literature

2.1 Cardiovascular Diseases

2.1.1 . Overview Cardiovascular Diseases

For thousands of years, we have had the same understanding of the causes of CVD and how to treat it. Only in the latter half of the twentieth century did research into the causes of CVDs become more prevalent, leading to the development of novel therapies. What caused this inquiry? The early death in 1945 of US President Franklin D. Roosevelt from hypertensive heart disease and stroke prompted this investigation in the United States. At the time, CVD and stroke deaths had reached pandemic proportions in the United States, motivating Americans to take the lead in cardiovascular research. The death of President Franklin D. Roosevelt highlighted how little we knew about the general causes of heart disease and stroke. (Hajar, 2017).

More than 85.6 million Americans suffer from one or more kinds of cardiovascular disease (CVD), which include hypertension, CAD, heart failure (HF), cerebrovascular disease and congenital cardiovascular disorders (Riegel et al., 2017).

Cardiovascular health (CVH) is characterized by the absence of CVD clinical symptoms together with appropriate levels of all life's basic functions. In the absence of medication therapy, they comprise four health behaviors (no smoking, a healthy food pattern, adequate physical activity, and normal body weight) and three health factors (normal total cholesterol, blood pressure, and fasting blood glucose) (Riegel et al., 2017).

Because of the frequency of CVD, nurses must be competent to assess the cardiovascular system in any environment throughout the continuum of care, including the home, office, hospital, long-term care facility, or rehabilitation facility. A health history, physical examination, and monitoring of a range of laboratory and diagnostic test findings are all important components of the assessment. This evaluation offers the information needed to establish nursing diagnoses, develop a customized plan of care, evaluate the patient's reaction to the treatment delivered, and change the plan as needed (Hinkle & Cheever, 2017.)

2.1.2 Types of Cardiovascular Diseases

The type of cardiovascular diseases can be divided as following:

1. Coronary artery disease (CAD): Also known as coronary heart disease (CHD), this condition is caused by reduced myocardial perfusion, which produces angina, MI, and/or heart failure. It accounts for 1\3 to 1\2 of all CVD cases.

2. Valve Diseases: Valve disease occurs when any of the four valves of the heart fails to open and close properly, causing blood flow to be disrupted. Congenital heart illness occurs when a problem in the valve occurs at birth.

3.Arrythmia or abnormal heart rhythm: This disorder produces a variation in the heartbeat that occurs even while the patient is at rest. Arrhythmia can be fatal if left untreated.

4. Heart failure with pulmonary edema (CHF) (E et al., 2022).

2.1.3 Risk Factors Related to Cardiovascular Diseases.

Risk factors are often described as variables that, when present in a person or a community, increase the likelihood of mortality or the development of a morbid disease compared to a risk-free person or society.

Geriatricians were typically willing to investigate characteristics that indicate impairment and physical, mental, and social functioning incapacity in the elderly, as well as risk factors for mortality or sickness. As a result, in addition to basic hypertension and malnutrition, they were focused on characteristics unique to old age, for example, sadness and loneliness (Valtorta et al., 2018).

The WHO and ACC\AHA have developed or published prediction that may be used to produce an absolute projection of a person's CVD risk. Lifestyle adjustments and preventative medication therapy are recommended for the management of major risk factors for cardiovascular disease. There are various risk factors for coronary artery disease, some of which can be treated but not all. Hypertension, high cholesterol levels, smoking, diabetes, being overweight or obese, a lack of physical activity, poor nutrition, and stress are all risk factors that may be addressed (modifiable). Age (simply getting older increases risk); sex (men are normally at a higher risk of coronary artery disease); family history; and race are all uncontrollable factors (conventional) (Hajar, 2017).

A. Modifiable risk factors

The impacts of high blood pressure, hyperlipidemia, and metabolic syndrome on cardiovascular mortality rates, as well as smoking, activity level, being overweight, and loneliness on heart disease and quality of life, show that cardiovascular diseases are commonly associated with risk factors. We may infer that particular, focused preventative interventions are best undertaken while people are young, but they can also help the elderly not only live longer but also live better lives (Noale et al., 2020).

1. Hypertension. Definition, Classification

For a long period, hypertension recommendations emphasized blood pressure levels as the sole or primary variable in determining the necessity and kind of therapy. In 1994, the European Society of Hypertension, the European Society of Cardiology, and the European Atherosclerosis Society issued joint recommendations on the prevention of coronary heart disease in clinical practice, emphasizing the importance of linking coronary heart disease prevention to the quantification of total (or global) cardiovascular risk (Kjeldsen, 2018).

In high-income nations, the prevalence of hypertension (defined as a range between systolic and diastolic (> 140 - > 90 mmHg) is typically fairly high, ranging (from 41 - 77.5 percent) in those over 60 and in people younger than 30 (4.3 - 19.7 percent) (Mills et al., 2016).

2: Obesity. Definition, Classification

Most experts believe cardiovascular risk has a link to overweight or obesity in young adults. However, the existence of a link between these characteristics in senior people remains a contentious question (Ebbert et al., 2014).

Framingham's research showed that Overweight and obese adults of both genders had an elevated risk of cardiovascular fatality. died at a rate shown in Individuals with a high BMI (up to the 70th percentile) that was 100 percent greater in women and 40 percent higher in males than those whose weight was between the 30–49th percentile (Flicker et al., 2010).

Recent research has revealed that the association between Body Mass Index and cardiovascular morbidity and death in senior adults may be A U-

shaped pattern was described, showing that unilateral losing weight efforts in the elderly may be futile (Wu et al., 2014).

Factors associated with the environment, together with genetic susceptibility, are believed to be key contributors to the contemporary obesity pandemic. a positive energy intake/energy expenditure imbalance leads to obesity, but the proportional impact of these components is unknown (Boccardi et al., 2018)

3. Diabetes Mellitus. Definition, Classification

Type 2 DM increases the risk of cardiovascular disease and mortality in the elderly. Although the relationship between CVD and DM is just less in elderly adults than in young adults, it remains a substantial risk factor causing CHF., Peripheral artery disease and claudication, particularly in women (Rhee & Kim, 2015).

4. Cigarette Smoking

A meta-analysis of people aged 60 and up found that smoking cigarettes were highly related to acute CAD events, strokes, and cardiovascular mortality. The risk of cardiovascular death was twice as high among smokers as it was among nonsmokers with the risk increasing with increased levels of cigarette usage. These findings indicate the importance of persuading senior smokers to quit smoking and the possibility of changing behaviors even at an advanced age (Mons et al., 2015).

A thorough study of young individuals has confirmed a significant link between smoking and cardiovascular morbidity and death. Despite becoming a controllable risk factor, few predictive studies have

investigated the effect of smoking on cardiac events as people age (Gellert et al., 2013).

At an even older age, studies show that tobacco remains a risk factor for coronary heart death and sickness, and that stopping may still be beneficial. Cigarette smoking causes cardiovascular morbidity by several pathophysiological processes, including vascular dysfunction, inflammatory, and muscle fibers proliferation (Ambrose & Barua, 2004).

5. Serum lipids

In advanced age in males, plasma cholesterol concentration rises from adolescence until (45 - 55 years) of age, when it tends to stabilize in their 60s. In women, cholesterol rises until ten years later, when it stabilizes in women in their seventies. (LDL), also known as atherogenic lipoproteins, tend to decline after 70 years of age **(Félix-Redondo et al., 2013).**

6: Physical Activity

a positive influence on a range of health disorders (cardiovascular illness, osteoarthritis, and overweight, for example) is widely established and a reduction in physical exercise has been found to raise the incidence of CVD, stroke, and coronary disease (Iijima et al., 2012).

However, much recent research has concentrated on middle-aged individuals, and little is known about the association between physical exercise and cardiovascular problems in the elderly. The favorable effect of physical exercise on cardiovascular disease might be attributed to either a direct action on the circulatory system or an indirect influence on specific risk factors. In the aged, for example, physical activity is inversely connected to blood cholesterol levels and blood pressure values, as well as

being directly related to glucose tolerance, insulin resistance, and cognitive function. Exercise has also been related to better lung ventilation and oxygenation (Fiogbé et al., 2017).

7: Socioeconomic Status

The absence of family and community support systems among the elderly is regarded to be a factor of risk for disease and death. Older widows and divorcees get a higher illness and mortality rate than older individuals who reside with their spouse or partner; it's been related to the loneliness that these individuals experience, as well as the added stress with a time of grief (Brenn & Ytterstad, 2016).

This link is often attributed to the fact of social connections encourage regular exercise, improve the mental condition, and provide vital support throughout the illness, all of which contribute to a person's health recovery. Similarly, changes in a client's self-social-economic standing (SES), which provides knowledge, salary, job, home circumstances, and other retirement-related characteristics, are linked to increased mortality and morbidity (Pabon et al., 2019).

8: Stress

Adults who are under stress at work or in their personal lives have a five-fold greater risk of CAD and stroke. Chronic stress acts as a disease trigger in people with high levels of atherosclerotic plaque, resulting in cardiovascular events (Kivimäki & Steptoe, 2018).

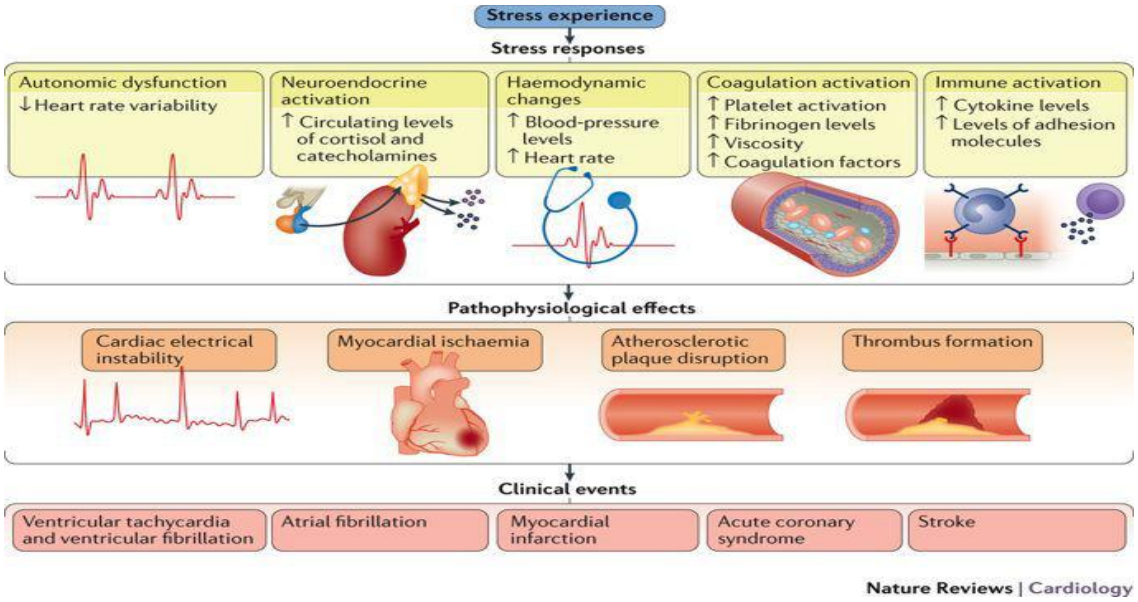

Figure 2-1.Effects of stress (Kivimäki & Steptoe, 2018) (Nature Reviews cardiology 2018).

B. Risk Factors (Non-Modifiable)

Cardiovascular disease (CVD) is the result of a mix of hereditary and environmental factors. These are known as risk factors, and many of them are under our control. Those who cannot are referred to be non-modifiable since they are beyond your control (Education & Leader, n.d.).

1. Age

Physiological alterations in the hearts of aged people have been documented, including reports of diastolic and systolic dysfunction, as well as electrical malfunction, including the development of arrhythmias. In aged individuals, both mechanical and electrical abnormalities contribute to a high prevalence of heart failure, arrhythmia, and many other CVDs. This population's high frequency of CVD has been attributed to several variables, including increased oxidative stress, inflammation, apoptosis, and total cardiac degradation and degeneration (Rodgers et al., 2019).

2. Gender

Overall, males are at a higher risk of having a heart attack than women, although the gap narrows as women approach menopause. This is due to a decline in estrogen levels, which raises the risk for women until it equals that of males. When other risk factors are comparable, the risk of heart disease after the age of 65 is essentially the same for both sexes (Maas & Appelman, 2010).

3: Family History

A family background of heart disease might help forecast your personal risk. A positive family history, mostly first relatives, is associated with a doubling of CVD risk. CVD is caused by both inherited and behavioral variables in the family. Adopting healthy lifestyle behaviors at a young age is crucial for minimizing your overall risk of CVD. (Maas & Appelman, 2010).

4. Ethnicity

People of the same ethnicity have a common cultural background or geographic origins. It is sometimes referred to as racing. ethnic group or race may be predisposed to CVD due to genetic factors as well as environmental factors. Individuals from the same ethnicity do have several genes, so their family history and race are tightly linked. People of similar ancestry may inherit similar gene mutations (Hunt et al., 2013).

Cardiovascular diseases is influenced from both changeable and non-modifiable risks and it is mostly preventable by healthy lifestyle changes. People must learn how to deal with and manage these risk factors. To reduce the prevalence of cardiovascular disease, it is critical to raise awareness among health care practitioners and systems serving Pacific

Islanders at a young age about providing accurate information, early screening and treatment, and recommending appropriate behavioral changes. (Mohammadnezhad et al., 2016).

2.1.4 Cardiovascular Diseases Epidemiology and Cardiovascular Predisposing factors

A. Cardiovascular Disease in the world

Except for Sub-Saharan Africa, CVD is a substantial public health burden and the biggest cause of overall deaths throughout the world. Due to population aging and expansion, the number of people dying from CVD grew by 15% in 2016, accounting for 17.6 million fatalities per year and is expected to climb to 23.6 million by 2030 (*Global Burden of Disease Study 2017*, 2017).

Between 2011 and 2014, the prevalence of CVD in people over the age of 25 in the United States was 36.6 percent. CVD accounts for 45% of all fatalities in Europe and 37% of all deaths in the European Union (Wilkins et al., 2017).In the United Kingdom in 2012, CVD was the second leading cause of mortality (28%), with CAD accounting for 46 percent of the mortality rate and stroke accounting for 26 percent (Bhatnagar et al., 2016).

B. Cardiovascular disease in the Arab countries

With the fast economic productivity in the Gulf region, there seems to be a change in lifestyle, including a rise in poor quality food intake and the adaptation of unhealthy lifestyles, and as an outcome, the percentages of CVD and risk factors associated among the Gulf citizenry have also increased; the percentages occasionally exceed those of developed nations (Mabry et al., 2010).

Additionally, the number of deaths from ischemic heart disease and hypertensive heart disease across the Middle East and North Africa (including the GCC member states) was 294/100,000 and 115/100,000, correspondingly. The quantity of disability-adjusted life years (DALYs) generated by ischemic and hypertension heart problems at about the same area is 3702/100,000 and 1389/100,000, respectively. In 2008, the WHO calculated the overall number of noncommunicable illnesses that resulted in mortality in the GCC states. CVD was predicted to account for more than half of all fatalities in Oman and Kuwait, accounting for 49% and 46%, respectively fatalities were also common in Saudi Arabia, the United Arab Emirates, Bahrain, and Qatar, with rates of 42%, 38%, 32%, and 23%, (Aljefree & Ahmed, 2015).

2.1.5 . Prevention of Cardiovascular Diseases.

Prevention seeks to enhance both the quality of life and the life expectancy of persons who have existing CVD, including those at high cardiovascular risk of developing CVD due to one or more risk factors. There are three methods of cardiovascular prophylaxis (primary, secondary, and tertiary) (Shahwan, 2018).

A: Primordial Prevention

Specific behavior lifestyle characteristics that achieve a standard of health which avoids risk factors from arising. AHA defines good cardiovascular health as a 20% reduction in stroke mortality by 2020 (Lloyd-Jones et al., 2009)

Because atherosclerosis develops at a young age, primary prevention is the only strategy to combat coronary disease. As they reach middle age, less than 5% of people attain the aim of primordial prevention; during this

time, Its cardiovascular prevention is good, because they get an extra ten years of life (Kullo & Cooper, 2010).

B. Primary Prevention

concerning those who have risk factors but no clinical signs of cardiovascular disease. Primary prevention aims to take action by arming communities with knowledge about healthy lifestyles, identifying risk factors and supplying nutritious meals It is the most expensive method of ensuring community health. by preventing illnesses and reducing or delaying the onset of CVD (Shahwan, 2018).

The goal of CVD prevention is to limit the occurrence of major cardiovascular events, thus minimizing premature disability and morbidity while simultaneously extending safety and quality of life. The American, European, and British recommendations reveal several approaches to minimize the CVD risk profile, with significant consensus for smoking and exercise, although the precise details for other variables may differ slightly. Pharmaceutical alternatives have evolved, although lifestyle advice has remained mostly stable. Primary prevention is evolving, and with the increasing availability of long-term data comes a better knowledge of how we might minimize CVD risk. It is an ongoing effort if we want to decrease the burden of preventable disease (Stewart et al., 2017).

C. Secondary Prevention

purpose of preventing complications and recurrences regarding CVD patients (CAD, stroke, LEAD). Early intervention can have a substantial impact on the development and expression of chronic illnesses (Shahwan, 2018).

D. Tertiary Prevention

Tertiary prevention aims to enhance life quality and total life expectancy by avoiding future problems**.** Tertiary prevention puts the greatest financial burden on the healthcare system because of the high cost of surgery and lifetime chronic disease treatment via drugs and rehabilitation (Shahwan, 2018).

2.2 . Elderly People:

2.2.1 Concept of the Elderly

Healthy aging has been described by (WHO,2014). The process of creating and maintaining functional capability is what allows older individuals to be happy. Functional ability pertains to a person's capacity to be and accomplish what they value. It is believed to be capable of meeting fundamental requirements, learning, growing, making decisions, being mobile, forming and maintaining relationships, and participating in society.

Aging is an inevitable aspect of life. Everyone must experience this era of life at their own pace and at their own time. Aging, in a broad sense, represents all of the changes that occur throughout life. These changes begin at birth and continue throughout a person's life as he or she grows, develops, and matures. Physical decline and functional incapacity are noticed gradually and persistently, culminating in increasing dependency in old age. In most industrialized nations, the age of 60 is recognized as the beginning of old age and is referred to as the retirement age (Amarya et al., 2018).

This functional ability is defined by WHO as the outcome of interactions between inherent capability and environmental stimuli. It is widely accepted that intrinsic capacity encompasses a person's mental and

physical talents. The environment's features are connected to the household, community, and society overall (Rudnicka et al., 2020)

Globally, the number of elderly people has increased significantly in recent years, with more elderly people alive now than at any previous time in decades. Every year, the proportion of the population aged 60 and over increases. As the population of older citizens increases, so does the likelihood of having chronic diseases. Chronic diseases cause physical, social, and psychological challenges that limit the elderly's participation in their communities. The assessment of the morbidity profile will help in the implementation of actions to enhance one's health and QOL of the aged (Hassanien et al., 2013).

The term elderly refers to those aged 60 and up, who represent the world's fastest-growing group. Despite occasionally significant numbers, the percentage of the elderly in developing countries is often modest. In 1990, more than 280 million people in developing nations were 60 or older, and 58 percent of the world's elderly resided in less-developed areas (George et al., 2017).

2.2.2 Characteristics changes of the Elderly.

A: Biological and Physiological characteristics and changes.

1: Cardiovascular physiology changes in older adults.

Aging causes changes in the cardiovascular system, which lead to alterations in physiology. Pathologies' effects, such as coronary artery disease, must be separated from changes in cardiovascular physiology, which occur in higher numbers as people age. Aging causes changes in the cardiovascular system, such as loss of elasticity and an increase in vascular resistance (Cheitlin, 2003)

These impacts occur in a cardiovascular system that has a lower maximum function compared to younger people, less reserve capacity, and the ability to fail to meet demands when pushed. Endothelial dysfunction is characterized by two symptoms: increased arterial stiffness and endothelial dysfunction. LV stiffness and cardiac capacity are both diminished. The parasympathetic and beta-adrenergic systems are also impacted (Dai et al., 2015).

B. The psychosocial change in Elderly

Age influences one's social and emotional life. Social networks are contracting. Emotions that have been experienced are less volatile and more predictable. Negative emotions become less prevalent (until extreme old age), and social roles vary quantitatively and qualitatively. Investing in real connections leads to growth. Some formerly straightforward social duties have become more complex as a result of diminished physical functioning. Sensory deficiencies impede conversation. Furthermore, a physiological function is less efficiently regulated (Charles & Carstensen, 2014)

2.2.3 Most common elderly problems with cardiovascular diseases

Sleep apnea: Sleep apnea is connected with an increase in the occurrence of sleep-related diseases with age. Due to repeated arousals, older people have difficulties sleeping and remaining asleep. Sleep pattern changes are a typical part of the aging process, and caregivers must be trained in the sleep habits of the elderly. Growing older does not usually imply poor sleep, although good sleep may undoubtedly enhance general health (Gulia & Kumar, 2018).

Nutritional concern: adequate calorie intake is a significant predictor of health status, particularly when degenerative disorders, such as aging,

become a major risk factor for difficult-to-treat illnesses (Mastronuzzi & Grattagliano, 2019).

Men's attention to depression and suicide risk within the first year after the death of a spouse, or depression following a hip fracture or stroke, may assist in averting age-related deterioration. By improving vision and hearing, you can prevent isolation, melancholy, and cognitive deterioration. Lower extremity strength, particularly quadriceps muscle strength, is required for basic daily actions such as bathing, walking, and performing transfers. In those over the age of 85, these muscles are needed for stability and to prevent falls. Eating a balanced diet throughout one's life can also aid in the prevention of diabetes, osteoarthritis, and other chronic diseases (Jaul & Barron, 2017).

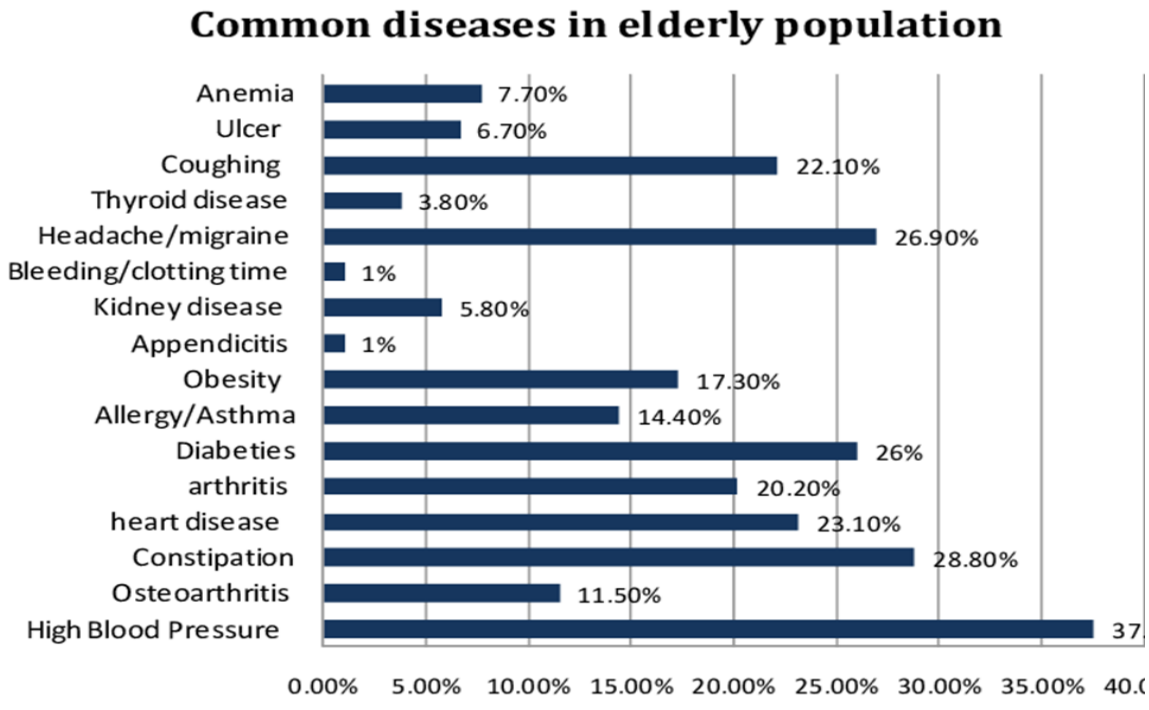

Figure 2-2 Common diseases encountered in an elderly population *(Kafeel, 2016)*

2.2.4 Needs of the Elderly people.

Financial stability, personal security, mental health, a functioning health-care system, and self-actualization are among the key needs of the elderly that should be satisfied in low- and middle-income countries. These needs are unsatisfactorily addressed until recently, and it remains tough in low- and middle-income countries. Fulfilling these core needs is necessary for healthy aging, which is an investment in the well-being of any society and its residents (Putri & Lestari, 2018)

Physical agony dominates everything, at least in the last stages of life. Furthermore, pain appears to make it difficult to recognize other psychological, social, and spiritual demands. The most prevalent sensation to be freed from is dread of physical pain, which stems from previous encounters with pain. Other significant requirements emerge when pain and other health issues, such as vomiting and shortness of breath, no longer cause fear of death. The sense of security provided by the presence of loved ones, as well as concerns for their future, appear to preoccupy the attention of a critically ill person even in the latter days of his or her life (Wijk & Grimby, 2008).

2.2.5 The Decade of Healthy Ageing 2020–2030 (a WHO program) Replaces Active Aging.

The World Health Organization created ten goals that provide concrete actions to fulfill the Decade of Healthy Aging objectives (2020–2030).

A. Establishing a change and innovation platform

B. Contributing to national planning and action,

C. Collecting more global data on healthy aging

D. Promoting research that meets the elderly's present and future needs.

E. Aligning health-care systems with aging requirements

F. Laying the groundwork for a long-term care system in every country.

G. Providing the necessary human resources for integrated care

H. Starting a worldwide anti-ageism movement Making an economic argument for investing

I. Establishing a global network of age-friendly cities and communities (WHO, 2020).

2.3. Quality of Life

2.3.1 . Historical Roots of the Concept of Quality of Life:

Medical and health care experts have created new quantitative methodologies and measurements to quantify degrees of well-being during the previous 30 years. These are sometimes linked to quality-of-life measurements. We chose the more descriptive phrase HRQL since it is normally used primarily to measure health status in people with medical conditions that affect daily functioning or create symptoms (Kaplan & Ries, 2007).

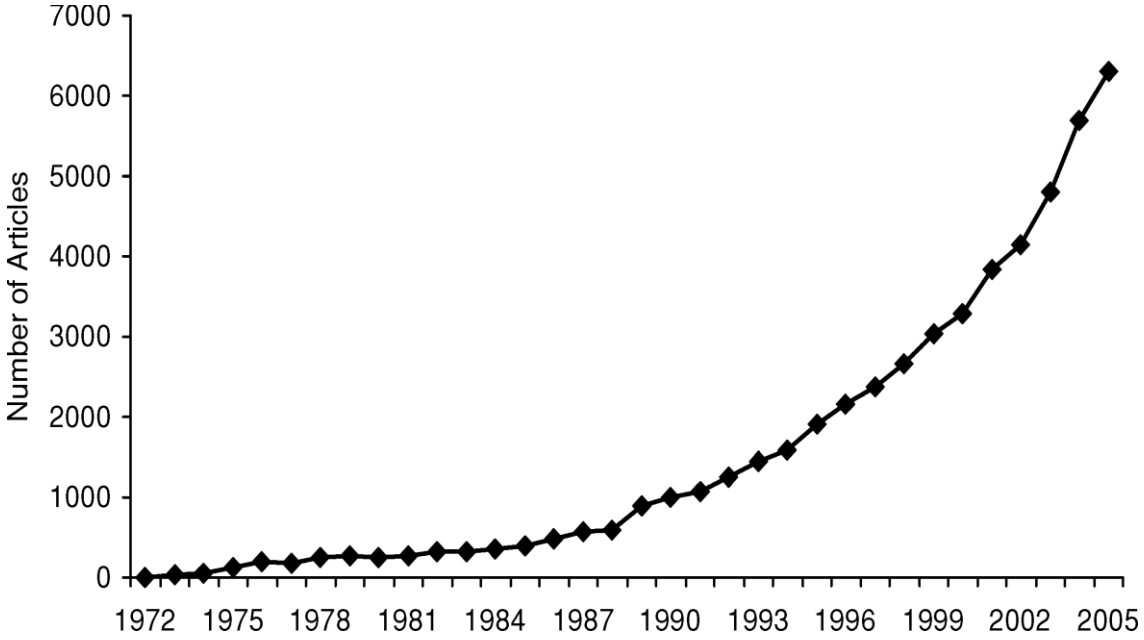

Figure 2- 3: The number of publications detected in the PubMed database between 1972 and 2005 using the phrase Quality of Life (Kaplan & Ries, 2007).

Figure (2-3) illustrates the number of particles detected in PubMed between 1972 and 2005 on the issue of quality of life. PubMed did not discover any papers with the topic category QOL in 1972. However, the number of publications using the keyword term quality of life increased considerably during the next 30 years. PubMed discovered 5345 similar items in 2005. The number of articles indexed under the quality of life term increased by 10% in one year, from 2004 to 2005. (over 600 articles). For numerous years, this pace of increase has been stable (Kaplan & Ries,

2007)

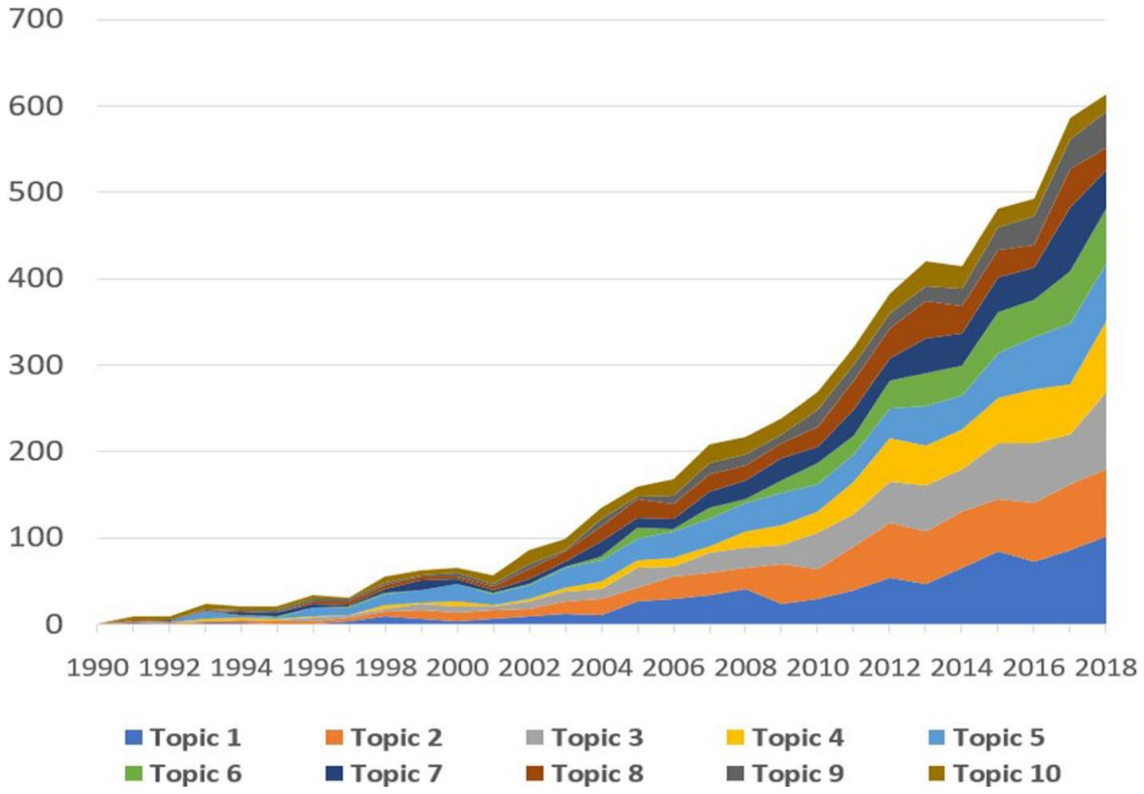

Figure 2-4:Changes in research topics development in QOL of CVD patients (Tran et al., 2020)

Quality of life has been widely employed in biomedical and nursing research during the last four decades, however, there is still no agreement on its definition and assessment. Many QoL instruments have been developed as a result of physicians and nurses using QoL as an important concept in making health-related choices, but they are based on differing conceptual interpretations (Pennacchini et al., 2012)

After WWII, there was a heightened awareness and comprehension of socioeconomic disparities, which sparked scholars' interest in life quality. This sparked study on social indicators and, later, subjective well-being and quality of life. According to the medical care literature, although the patient's perspective on his or her health has long played a role in medical

consultation, researchers did not begin collecting and evaluating such data systematically until the 1960s (Jenkinson 2. M., p. 2020).

2.3.2 . Quality of life concept& definition

A poor-quality life in elderly people is similar to a loss of health, whereas a high QOL is corresponding to a broader range of categories such as activity, income, social life, and family relationships, which vary from subject to subject (Xavier et al., 2003).

Older individuals' assessments of their QOL in terms of personal variables, social involvement, and environmental aspects. The contribution is primarily concerned with QOL conceptualization; namely how human functioning components are vital for QOL. The emotional life, a personal aspect element, was especially important. Individual aspirations were often balanced by social engagement and environmental circumstances. It is possible to generate new knowledge based on participants' views and experiences, which may be used to enhance information on QOL collected through more traditional approaches (Tribble & Desrosiers, 2009).

2.3.3. Theories Explaining the Quality of Life.

When Abraham Maslow wrote his book Towards a Psychology of Being in 1962, few could have predicted that he had constructed a theory of quality of life, which is still regarded as a consistent of quality of life theory yet after 40 years. Maslow defined the perfect existence as a progression through the eight requirements. To achieve them one by one, we should train our minds and bodies to be more spontaneous, autonomous, energetic, and accountable (Ventegodt et al., 2003).

Figure 2-5: Maslow's hierarchy of needs, is represented as a pyramid with the more basic needs at the bottom.

The philosophy of life evaluates the overall quality of life; however, we can do so following an integrated of quality of life theory, such as the IQOL theory. The IQOL theory is a meta-theory that comprises eight more factual theories on a subjective-existential-objective spectrum. Other life philosophies and QOL concepts may place greater emphasis on other aspects of life (and do so). We must not presume that everyone agrees on nature or the fundamental depths of our existence. Incorporating such depth into the health and social sciences, on the other hand, appears to be a critical step toward a new humility and reverence for the richness and complexity of existence (Ventegodt et al, 2003).

While various definitions and concepts of QoL have been proposed, a comprehensive study of older people's perspectives is absent. Understanding what is essential to older persons in life is vital for connecting care service goals with their desires. Furthermore,

understanding quality of life from the standpoint of older persons is required for determining the validity and reliability of established QoL measures (van Leeuwen et al., 2019)

2.3.4. Quality of life domains

QOL aspects contents four domains: physical domain ('perception of health, autonomy, role and activities). psychological domain (attitude and adaptability, emotional comfort and spirituality). Relationships at home and in the neighborhood are a social domain. Financial security in the environmental area.

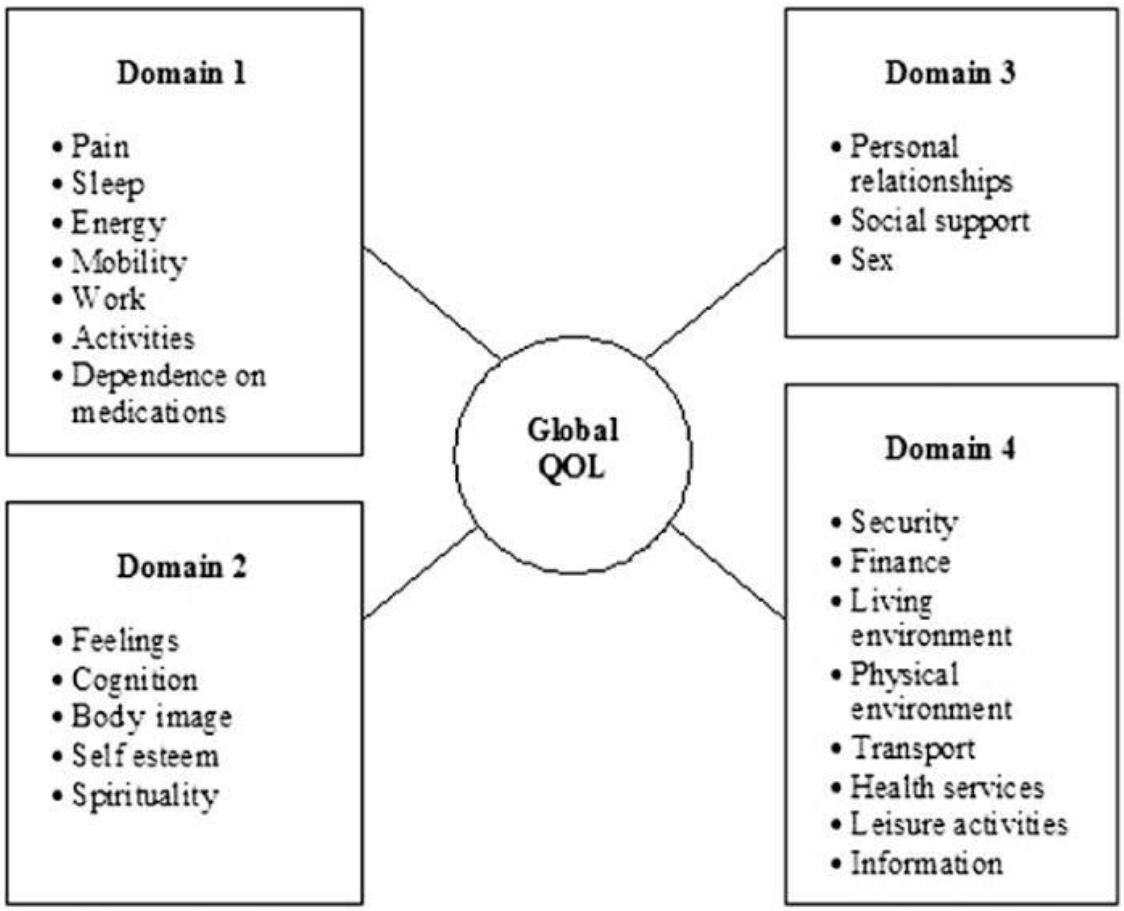

Figure 2-6: QOL domains (Thakar et al., 2009)

In the section, each area is further discussed and illustrated using quotations.

Table 2-1 provides an overview of the domains & subtopics (van Leeuwen et al., 2019)

Domains and subthemes	Description
Health perception	**Feeling healthy and not limited by your physical condition**
- [Physical conditions and symptoms]	- Not suffering from physical, mental and cognitive symptoms or disorders
- [Point of reference]	- Feeling healthy compared to prior health status or that of others
- [Health as an ability]	- Not being limited by your health
Autonomy	**Being able to manage on your own, retaining dignity and not feeling like a burden**
- [Independence]	- Being able to manage on your own and do what you want
- [Control]	- Being able to choose what you want
- [Burden]	- Not feeling like a burden to others
- [Dignity]	- Being able to retain dignity by focusing on things that one can do
Role and activity	**Spending time doing activities that bring a sense of value, joy and involvement**
- [Control over time]	- Having the freedom to organize your time
- [Keeping busy]	- Having something to stay occupied and keep you from feeling bored
- [Valuable activities]	- Doing activities that bring joy or meaning to life
- [Staying connected]	- Staying mentally active, up-to-date and in touch with the world around you
- [Helping others]	- Feeling able to contribute to society and making a difference
- [Achievements]	- Being proud on (and achieving a sense of identify from) current and former achievements
- [Self-worth]	- Feeling valuable and comfortable in your own skin
Relationships	**Having close relationships which makes you feel supported and enable you to mean something for others**
- [Close relationships]	- Having (and keeping) valued relationships
- [Family]	- Enjoying bond with partner and/or (grand)children
- [Experiencing support]	- Experiencing that people care for you and care about you
- [Love and affection]	- Experiencing a sense of belonging and intimacy, being loved and appreciated
- [Reciprocality]	- Having the possibility to help and support others
Attitude and adaptation	**Looking on the bright side of life**
- [Positive attitude]	- Being positive and making the best out of life
- [Acceptance]	- Being able to accept what you cannot influence
- [Changing standards/ expectations]	- Being able to put your situation into perspective (cognitively minimizing effects of deteriorations by lowering standards and comparing yourself favourably to others)
- [Changing behaviour]	- Being able to change habits, do things differently or with assistance from others/ aids
Emotional comfort	**Feeling at peace**
- [Calm vs worried/anxious]	- Having peace of mind (not feeling worried or anxious)
- [Happy vs sad/depressed]	- Being happy (not sad or depressed)
- [Loneliness]	- Not feeling lonely or isolated
- [Reminiscence]	- Not feeling troubled by past experiences
Spirituality	**Feeling attached to and experiencing faith and self-development from beliefs, rituals and inner reflection**
- [Being religious]	- Having religious beliefs, faith in God
- [Being spiritual]	- Being on a quest for meaning, self-development and awareness
- [Religious activities]	- Being involved in religious activities or a religious community
Home and neighbourhood	**Feeling secure at home and living in a pleasant and accessible neighbourhood**
- [Meaning of home]	- Having a home that provides privacy and comfort
- [Living at home]	- Living as long as possible in your own home
- [Safety]	- Feeling safe and secure at home and in the neighbourhood

(*Continued*)

Financial security	Not feeling restricted by your financial situation
- [Sufficient money]	- Having sufficient money to meet basic needs
- [Financial freedom]	- Having the financial freedom to enjoy life
- [Materials and conditions]	- Having material resources to feel comfortable and independent

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A. Physical Domain:

Feeling well and unconstrained by healthy perceptions is all about is your physical condition. Health is regarded as a vital, and sometimes even critical, component of QoL (Bernardo Gonçalves Marques et al., 2014).

The extent to which older people considered healthy and active or suffering with physically, psychological, and intellectual deficits influenced their health perception. Complaints, activity impairment, and pharmacological adverse effects (including such poor balance, poor memory, discomfort, vision loss, and weariness) all had a detrimental impact on their QoL (Romo et al., 2013).

Autonomy is defined as the ability to manage on your own while maintaining dignity and without feeling like a burden. Many elderly persons express a wish to remain independent for as long as feasible (Åberg et al., 2005).

Putting time in actions that generate a sense of value, excitement, and engagement. Management over how they spend all their time is essential for elderly people who live at homes (Tribble & Desrosiers, 2009).

B. Psychological Domain

Keeping a good attitude in the face of hardship is an example of attitude and adaptability. The elderly strongly believes that having a positive attitude adds to having a higher quality of life. According to elderly people who have chosen such a life philosophy, be cheerful, enjoy life, be pleased

with small things, make the most of life, and keep your humor, optimism, and curiosity. They emphasize the significance of not feeling sorry for oneself, constantly moaning, or sitting around doing nothing. Aging is frequently equated with 'being in a new reality (Romo et al., 2013).

Emotional comfort: a sense of well-being. Older individuals expressed a desire to be tranquil, comfortable, worry-free, in harmony with life, and at peace with themselves. However, for some, these sensations are limited by stress and concerns for loved ones, as well as a low income, health, and independence (Llobet et al., 2011)

Spirituality is defined as a strong attachment to and experience of religion, as well as self-development via beliefs, rituals, and interior contemplation. Being religious or spiritual can help older persons accept disability or psychological suffering, cope with changes, and be content with their lives (Malone & Dadswell, 2018)

C. Social Domain

Having intimate relationships allows you to feel supported and also to make a difference in the lives of others. Social connections are viewed as important for older individuals' QoL because They help them avoid isolation. Personal relations are extremely valuable since the quality of connection is the most important component (From et al., 2007).

Home and neighborhood: Having a safety home to live and living in a nice and accessible community. For older persons, the sense of home frequently extends beyond simply a domicile; it evokes sentiments of remaining in a comfortable environment with familiar and essential things as well as shared customs, history, and values (Ebrahimi et al., 2013).

D. Environmental Domain

Financial security entails not feeling constrained by one's financial condition. A good financial situation makes life simpler. The capacity to satisfy fundamental requirements was cited by respondents (Bowling et al., 2007).

2.3.5. Quality of life Measurement &Tools.

Quality-of-life assessments are divided into several categories. Firstly general measures, which are intended to assess HRQOL in any group of patients (or, evidently, in any population sample); secondly disease-specific measures, such as those intended to assess health-related quality of life in specific illness groups; and finally individualized measures, which allow for the incorporation of facets of life that individual patients find important. They also address problems that may be widespread among people who are afflicted with certain diseases (e.g. a sense of powerlessness and perceptions of social stigma) (Jenkinson, 2020, May 6).

Quality of life measuring tools: The most regularly used standard questionnaires in cardiovascular disease are as follows:

A. WHO Quality of Life scale.

ThisistoolWHOQOLconsiderssixdomains: Spirituality/religion/personal views, physical health, personal autonomy, psychological health, environment, social interactions. The WHOQOL-100 questionnaire has 100 items and allows for the measurement of QoL in connection to 28 sub-dimensions from the areas listed, and also overall QOL and self-perceived well-being. A smaller version of a tool (WHOQOL-Brief) with 26 items and strong psychometric qualities was created; It measures four aspects of

quality of life: physical health, mental health, social relationship and the environment. (Gierlaszyńska et al., 2016).

B. Health Survey (Short Forum -36).

149 questions in the so-called lengthy MOS version are divided into 16 categories. The SF-36 scale was created based on this version, and its contents of 36 questions divided into eight domains: role limitations due to physical health problems (RP; role-physical), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), role limitations caused by emotional problems (RE; role-emotional), and psychological health (MH). A kinds can be split into 2 overview measurements that describe the physiological (PCS) and psychological (MCS) elements, respectively. (Klocek et al., 2005).

C. Profile of Health in Nottingham (NHP).

The questionnaire, which was created in the eighth decade of the twentieth century, is broken into two sections. The first is made up of 38 questions, while the second is made up of 7 single statements. The respondent's physical, mental, and emotional dimensions, as well as social ties, are all addressed. The maximum score is 100; the greater the score, the more serious the health issues. The score does not include the respondents' overall well-being but instead focuses on the negative elements of their performance (Gierlaszyńska et al., 2016).

D. Euro-QOL scale (EuroQoL, EQ-5D)

A scale for evaluating people aged 12 and up was established at the end of the 20th century. Normal activities (job, household tasks, study, relaxation, family), self-care, movement, anxiety/depression, and physical stress are all included in the survey. It is divided into two sections: firstly

the EQ Index, which includes analyses of QoL within the above-mentioned categories, and second which respondents use to display their health evaluation graphically (in the form of a thermometer), with 100 denoting the best possible condition and zero denoting the worst possible condition called the EQ-VAS (Klocek et al., 2005).

2.3.3 . Improving the Quality of Life.

From 1990 to 2018, the number of research publications on therapies to enhance QOL in people with CVD rose progressively. The study's research topics stressed the necessity of multidisciplinary and inter-sectoral methods in both evaluation and intervention. The most prevalent techniques were conventional therapy (surgery and medication), as well as psychological and behavioral approaches (Tran et al., 2020).

Cardiac rehabilitation increases QoL in CHD patients, and QoL improvements have a bidirectional link with increased physical activity and vocational status, which improves QoL even more and may lower mortality. Home-based programming provides patients with additional options and may be especially beneficial in increasing adoption among older CHD patients who are more sensitive to the advantages of cardiac rehabilitation. Furthermore, evidence of felt well-being indicates QoL advantages in addition to mortality benefits for nurses advocating participation in cardiac rehabilitation programs. It also strengthens the commercial case for cardiac rehabilitation as professionals seek program financing in competitive health economies (Shepherd & While, 2012).

In most situations, heart failure is a progressive illness with a poor prognosis. However, low quality of life is not unavoidable and many medical, surgical, and non-pharmacological therapies can assist individuals to maintain or enhance QOL with heart failure (Freedland et al., 2021).

2.4 Previous Studies

2.4.1 . First Study:

(Mousa et al., 2014).

"Patients' Health-Related Quality of Life After Percutaneous Coronary Intervention In Baghdad City"

Method: descriptive research conducted at the Iraqi Centre for Heart Disorders (Ibn Al-Nafees, Ibn-Al-Betar centers in Baghdad City from October 2nd, 2012, to July 30th, 2013. A 100 patients was gathered purposive (non-probability) sample via personal interviews using a questionnaire form constituted of two section, the first of which included socio-demographic and medical history item and the second of which included a shortened version of a 12-item health survey scale for assess QOL in patients. Cronbach's alpha of.882 was used to measure the reliability of the surveys. The data were analyzed using frequency, percentage average, standard deviation, relative sufficiency and contingency coefficient.

Result: The current study found that a significant linked between age and physical function. A study revealed patients after percutaneous coronary intervention have a low level of QOL for the overall health and vitality domains, a moderate level for physical function, bodily pain, and mental health domains, and a high level for role physical, role emotional, and the role social health domains

2.4.2 . Second Study

(Mohammed, 2017).

"The Relation between Life Quality and Angina Pectoris Patients in Hospitals in Kirkuk City"

Method: The study, which was conducted at Azadi Teaching Hospital and Kirkuk General Hospital in Kirkuk City, used a descriptive design (a convenient sampling) to assess the QoL in Angina Pectoris patients. Study conducted from the 20th of October 2015 to the 15th of August 2016. It included 100 patients. To obtain the necessary data, a questionnaire was created based on the WHO scale requirements. The total number of elements in the questions was (90).

Result: The study found that a large percentage (26%) of the study group was between the ages of 40 and 49 (and 70) years old. Males account for the vast majority of patients (60 percent) in terms of gender. According to the data analysis, various demographic factors (age, employment, and duration of angina) are more commonly significant (affected) in QOL domains. The physical domain accounts for the majority of elements of life in angina pectoris patients and It has been linked to a wide range of socioeconomic factors.

2.4.3 . Third Study

(Azami-Aghdash et al., 2019)

"Cardiovascular Disease Patient's Quality of Life in Tabriz City in Iran in 2018".

Method: The research in 2018 at Tabriz University of Medical Sciences conducted. The convenience sample method was used to choose 180

participants for this study. Data was gathered using the WHOQOL-BREF adapted questionnaire. A questionnaire with 26 items about patients' QOL was employed contents different aspects.

Result: The vast majority of participants (about 80%) were between the ages of 50 and 69. Only about a 30 percent of those surveyed were happy with their wellbeing, but only 12% said they might afford their demands. Only about half of those responded to the survey are satisfied with their ability to run day-to-day operations. Age, residence, level of education, and income all had a statistically significant link with QOL. Conclusion: QOL is poor in CVD patients in Iran. As a result, more research on the aforementioned criteria is required to plan for enhancing QOL in these individuals.

2.4.4 . Fourth Study
(Komalasari et al., 2019)

"Quality of Life of People with Cardiovascular Disease: A Descriptive

Study ":

Method: The study was performed in a private hospital's outpatient department in Tangerang, Banten Province, Indonesia. This quantitative, descriptive study included 397 elderly patients. Data was collected through purposeful sampling. Patients with a history of CVD aged 60–74 years (cardiovascular disorders). Physical wellbeing, psychological characteristics, social relationships, and the environment were all assessed using the WHOQOL-BREF survey questions. The data were analyzed using descriptive analysis. According to the data, 94 percent of CVD respondents had a high quality of life, with 85 percent having an adequate environmental component, 60.7 percent having active social contacts, 54.7

percent having good physical health, and 44.8 percent having a balanced psychological state.

2.4.5 . Fifth Study
(Kim et al., 2021).

"Health-related quality of life and readmission of patients with cardiovascular disease in South Korea"

Method a cross-sectional study came from 1037 people diagnosed with CVD. Original data for the four to six (Korea National Health and Nutrition Examination Surveys (2007–2014)) were gathered.

Result Age, housing status, educational status, unemployment, personal Having to walk times per week, monthly income, cerebrovascular disease, rheumatoid arthritis, DM, depressed mood, low-stress level, and activity limits owing to cardiovascular disease were found to be linked with readmission.

Conclusion, readmission was associated with HRQOL in individuals with a myocardial injury. Therapies that aim to prevent hospitalizations by improving diagnosis and establishing a system of care for CVD symptomatology are required.

2.4.6 . Sixth Study
(Tofighi et al., 2012).

"Health-Related Quality of Life among Patients with Coronary Artery Disease: A Post-Treatment Follow-Up Study in Iran"

Objectives: look at modifications in QoL in people with CAD in Iran.

Methods: In the first- and third-years following therapy, 49 patients completed the Iranian translation of the 36-item short-form (SF-36) questionnaire to assess HRQoL.

Result: During the follow-up period, the mental component summary scale improved while the physical component summary scale decreased. Multiple regression analysis showed that the rating one year after treatment was the most important predictor of HRQoL at the follow-up and that there were no significant variations in HRQoL changes based on intervention, age and gender.

Chapter Three

Methodology

Chapter Three

Methodology

This chapter presents all methodological and procedural principles which are approved in an organized method to reach the objectives of the study

3.1 . Design of the Study.

The study design reveals the general technique used to unite the different components of the study logically and coherently, It is critical to remember that the approach need to choice is dictated by the research topic, but never the other way around (de Vaus, 2001).

To accomplish the study's objective, the current study is a descriptive study that employs an assessment technique.

The study was conducted on Imam-AL Sadiq teaching hospital, Marjan teaching hospital and Shaheed AL mihrab for cardiac diseases& surgery center from the period of 1st October 2021 to 15 May 2022.

3.2 Administrative Agreements:

The administrative permission for data collection was obtained as presented in Appendix (A):

1. Official agreement was acquired from the University of Babylon/ College of Nursing/ Higher education committee after a protocol Presentation to the director of health Babylon.

2. An ethical committee of the Department of family& community health Nursing at Babylon University / College of Nursing has approved the protocol of the study.

3- Agreements of the directors of two Teaching hospitals and specialist cardiovascular diseases center in Babylon province, which includes at a margin teaching hospital, imam Sadiq teaching hospital and Shaheed AL mihrab for Cardiac diseases and surgery Center.

3.3 . Setting of the Study

The study was conducted in the following areas:

1. Shaheed Al Mihrab Cardiac diseases and surgery Center: located in Babylon governorate, patients are treated for a number of conditions, including coronary heart disease, lower extremity peripheral artery disease, valvular heart disease, renal artery stenosis, hepatic vascular disease, and others. The center content: cardiac care unit, catheterization operation room, open heart department and outpatient department.

2. Imam-Sadiq teaching hospital: This hospital was established to receive Babylonian citizens in 2017, the total capacity of this hospital is 503 beds. data collect from the cardiac care unit consists of (12) beds,

3. Marjan teaching hospital: This hospital was established in (1957) and is considered the first general teaching hospital in Al-Hilla city, it specialized to receive medical cases, the total capacity of the hospital is (316) beds. data collect from the cardiac care unit consists of (16) beds,

3.4 . Sample of the Study:

Purposive (non-probability) Sample is predicated on the researcher's decision through choosing the components to be studied and is also known as judgement, discriminating, or subjective sampling. (For example, patients, situations, or particles of data) (Rai & Thapa, 2015).

Purposively 120 patients of both genders of elderly age, medically diagnosed with cardiovascular diseases visit to hospital and outpatient department.

Table 3-1. Show Sample of the study

Hospitals	No.		N0. Of subject
Imam sadiq teaching hospital	80	25%	20
Margin teaching hospital	120	25%	30
Shaheed Al-mihrab for diseases &surgery center	280	25%	70
Total	480	25%	120

3.4.1 . Inclusion Criteria

For selecting the sample

1. who aged 60 years old and above.

2. who have duration disease more than 6months

3. who agreement to participation in the study.

3.4.2 . Exclusion criteria

1. patients aged under 60 years.

2. who have duration disease less than 6months

3. Patients who decline to participate in the research

3.5 The Study instrument:

This questionnaire developed by (WHO-breef 2012) inquiries about your life quality, wellness, and other aspects of your life.

The researcher and supervision modify in a questionnaire after extensive articles and literature revisions to assess the quality of life for elderly people with cardiovascular diseases in Al-Hilla city.

The instrument consists three-part;

3.5.1 Part 1: socio-demographic data:

The socio-demographic data was composed of (7 items), which involved: age, gender, marital status, resident, level of education, Occupation, socio-economic status (income monthly, Number of family members).

3.5.2 Part 2: medical history

Consist of (3) items: Type of cardiovascular diseases, duration of diseases (<1 year,1-2 years,>2 years), and other chronic diseases

3.5.3: General health and Quality of life domain:

General health domain, Physical health domain, Psychological health domain, Environmental health domain and Social relationship.

3.6 . Rating and Scoring:

Mean of scores calculated as follows

$$M.S = \frac{f1*s1 + f2*s2 + f3*s3}{N}$$

M.S. = mean of scores, f = frequencies, S = scores, N = numbers of sample.

$$\text{Range of Score} = \frac{\text{Max(M.S)} - \text{Min (M.S)}}{\text{Rating}} = \frac{3-1}{3} = 0.66$$

The items were classified and scored according to the patterns below:

1. Three scales are used in quality of life for the elderly with cardiovascular diseases. The three points are scored in positive items as (1) for never, (2) for some time, and (3) for always, in negative items as (1) for always (2) for some time, and (3) for never.

2. Three scales are used in general health quality of life for elderly with cardiovascular diseases rating the items as good, Neither, poor. The three points are scored in positive items as (1) for poor, (2) for neither, and (3) for good,

To determine the score of quality of life for elderly with cardiovascular diseases, the researcher divided the scales into three levels like the following: Table (3-2)

Table3.1 Rating and scoring

Quality of life	**(1 - 1.66)**	poor
	(1.67 – 2.33)	**Moderate**
	(2.34 – 3)	good

3.7 . Validity of the instrument of study:

The questionnaire was validated through the exposure of the tool to (13) specialists and expert, from different fields, with no less than (10) years of experience in investigating the specificity, validity, and adequacy of the questionnaire to assess the concept of interest, all of its recommendations have been taken into account. A preliminary print of the questionnaire was developed and sent to those (13) experts.

3.8 . Pilot of the study:

The pilot study was carried out on (12) Elderly with cardiovascular diseases in al-Hilla City from the period 1-10 February 2022. This sample was not included in the main study sample.

The pilot study seeks to answer the following issues: The tool's reliability, an estimate of the time needed to collect the data, Identification of barriers that may not be counted during the data collection process and Identification of the accuracy and appropriateness of the sampling.

The pilot study result was:

1. The tool is reliable.

2. The questionnaire's items are clear and can be understood easily.

3. The period required to complete the questionnaire ranged from (15-20) minutes.

3.9 Study instrument Reliability:

Reliability is concerned with a testing instrument being consistent and reliable in calculating a variable. Alpha Cronbach was used as a statistical method to achieve the reliability of the questionnaire; the feedback form depends on the calculation of the correlational coefficient.

$$\alpha = \frac{k}{k-1}\left(1 - \frac{\sum V_i}{V_t}\right)$$

Usually, determine the degree of reliability by using the link procedures. Reliability coefficients range typically from (0.00) to (1.00). Reliability is the coefficient above (0.70) satisfactory.

Table 3-3 Alpha Cronbach

No. Variables	Items	Alpha Cronbach	Assessment	Accept Value
Quality of life	**30**	**0.81**	**accepted**	**0.70-1.0**

3.10Methods of data collection:

Data were collected after acquiring an official agreement from the department of development and a training/branch of studies and research in Babylon health directorate (Appendix A), through using research instruments in the period from 11 February to 25th May 2022. using the Arabic version and by interviewing all participants inclusive in the research sample similarly, the same questionnaire was used at the same place to achieve the objectives of the research. The duration of answering the questionnaire takes approximately (15-20) minutes

3.11. Methods of Statistics Data Analysis

In order to statistically analyze the data collected from the study sample to arrive at the results, the researcher used the SPSS *ver-26* and Microsoft Excel (2010) program to analyze this data and deal with it statistically, to find the relationships between the variables, and obtain the final results of the research based on a set of statistical tests.

1. Descriptive approach

Descriptive statistics refers to a collection of statistical and mathematical approaches used to statistically characterize the key properties of data using tables and charts. Descriptive statistics always aim to present and describe the data which is required to be processed, organized, summarized and categorized, as well as presenting them in a

simple and clear manner that makes it easier for the recipient to recognize and understand its content. The analysis performed through use:

1. "Frequencies and Percentages" statistical tables:

$$\% = \frac{Frequency}{Sample\ Size}\ x100$$

2. Mean of scores "*M*±".

The average score can be calculated by using the following:

$$M.S = \frac{\sum \text{ri} = 1\text{Fi x Si}}{\sum \text{ri} = 1\text{Fi}}\ x100$$

Quality of Life Scores

The overall responses according to total mean of score which follow:

M= 30-50 refers to Poor QoL.

M=51-70 refers to Moderate QoL.

M=71-90 refers to Good QoL.

C. Standard Deviation test ±*SD*.

$$SD = \sqrt{\frac{1}{n-1}\sum_{i=1}^{n}(Xi - \bar{\chi})^2}$$

D. It uses a correlational coefficient "Cronbach alpha" used in estimating the internal consistency of the study tool,

2. Inferential approach

Chi-square test.

A Chi-square test is a hypothesis testing method. Two common Chi-square tests involve checking if observed frequencies in one or more categories match expected frequencies.

$$\chi^2 = \sum \frac{(O - E)^2}{E}$$

χ^2 = the test statistic $\sum$ = the sum of

O = Observed frequencies E = Expected frequencies

"The following abbreviations are used to the measurement of comparable significance":

- "H. S: Highly significant at $P \leq 0.01$"
- "Sig: Significant at $P \leq 0.05$"
- "N. S: No significant at $P>0.05$

Chapter Four

Results of study

Chapter Four

Results of the Study

Under the objectives of the current study findings, the descriptive and inferential statistic approach organized in tables and figures that includes the following:

4.1. Descriptive Statistic of Sample Characteristics.

Table 4-1-1: Descriptive Statistic of Socio-Demographic Variables

SDVs	Classification	Freq.	%
Age/years	60-69 years	87	72.5
	70-79 years	21	17.5
	≥80 years	12	10.0
	Total	120	100.0
Gender	Male	58	48.3
	Female	62	51.7
	Total	120	100.0
Marital status	Single	4	3.3
	Married	101	84.2
	Widower	15	12.5
	Total	120	100.0
Education level	Illiterate	8	6.7
	Elementary school	52	43.3
	Intermediate school	24	20.0
	Institute and above	36	30.0
	Total	120	100.0
Occupation	Jobless	41	34.2
	Free work	15	12.5
	Retired	40	33.3
	Employ	24	20.0
	Total	120	100.0
Socio-economic	Insufficient	54	45.0
	Sufficient to certain limit	52	43.3
	Sufficient	14	11.7
	Total	120	100.0
Residents	Urban	96	80.0
	Rural	24	20.0
	Total	120	100.0

This table displays the age range 120 participants who participated in this study varied from 60 to 69 years old, accounting for 72.5 percent of the

study sample. In regards to gender, most of studied sample were female (51.7%) as compared with those who are male. Marital status related findings, most of participants (84.2%). Respected to the education level, the elementary school composed the highest percentage (43.3%). Occupation associated findings; the elderly people exhibited jobless (34.2). In terms of socio-economic status, it is obvious from the findings that the insufficient economic records the highest (45%) and residents in urban areas (80%).

Table 4-1-2: Descriptive Statistic of Medical History.

Medical history	Classification	Freq.	%
Type of medical history	HF	28	23.3
	CAD	57	47.5
	Valvular diseases	17	14.2
	Arrhythmia	18	15.0
	Total	120	100.0
Duration of disease	<1 year	41	34.2
	1-2 years	35	29.2
	>2 years	44	36.7
	Total	120	100.0
Others chronic diseases	Yes	57	47.5
	No	63	52.5
	Total	120	100.0

Medical history related findings, most of people had history of coronary artery diseases (47.5%). Concerning duration of disease, patents expressed more than 2 years with disease (36.7%). Most of people (52.5%) exhibited no suffers of other chronic diseases as compare with those (47.5%) with chronic diseases.

4.2. Quality of Life for Elderly People with Cardiovascular Diseases.

Table 4-2-1. Quality of life -related to General Health.

List	QoL of General Health Items	Responses	Freq.	%	*MS±SD*	*Ass.*
1	How would you rate your quality of life?	Poor	88	73.3	*1.28±0.488*	*Poor*
		Neither	30	25.0		
		Good	2	1.7		
		Total	120	100.0		
2	Do you have feelings of satisfaction with your health?	Never	86	71.7	*1.34±0.586*	Poor
		Sometime	27	22.5		
		Always	7	5.8		
		Total	120	100.0		
3	*Do you worry about your health?	Never	17	14.2	*1.42±0.729*	*Poor*
		Sometime	17	14.2		
		Always	86	71.7		
		Total	120	100.0		
4	Do your personal beliefs help you to understand difficulties in life?	Never	12	10.0	*2.23±0.618*	*Moderate*
		Sometime	68	56.7		
		Always	40	33.3		
		Total	120	100.0		
5	To what extent do you feel you have control over your life?	Never	96	80.0	*1.30±0.658*	*Poor*
		Sometime	11	9.2		
		Always	13	10.8		
		Total	120	100.0		
6	You are able to manage personal difficulties	Never	93	77.5	*1.32±0.650*	*Poor*
		Sometime	15	12.5		
		Always	12	10.0		
		Total	120	100.0		

** negative item*

In terms of statistical mean and standard deviation, this table demonstrated that the elderly people expressed a poor response regards general health status as indicated by low mean scores at all studied items except, the elderly people expressed a moderate level related to personal beliefs that help them to understand difficulties in life as indicated by

moderate mean scores.

Table 4-2-2: Overall Quality of Life-related to General Health among Elderly People with Cardiovascular Diseases.

General Health	Freq.	%	*M ± SD*
Poor	108	90.0	
Moderate	10	8.3	*8.91±1.590*
Good	2	1.7	
Total	120	100.0	

M: Mean (total score), SD=Standard Deviation (total score)

(*Poor= 6-10; Moderate=11-14; Good=15-18*)

The findings illustrated that the majority (90%) of elderly people with cardiovascular diseases exhibited a poor quality of life associated with general health at a Mean and (±SD) = *8.91* (*±1.590*).

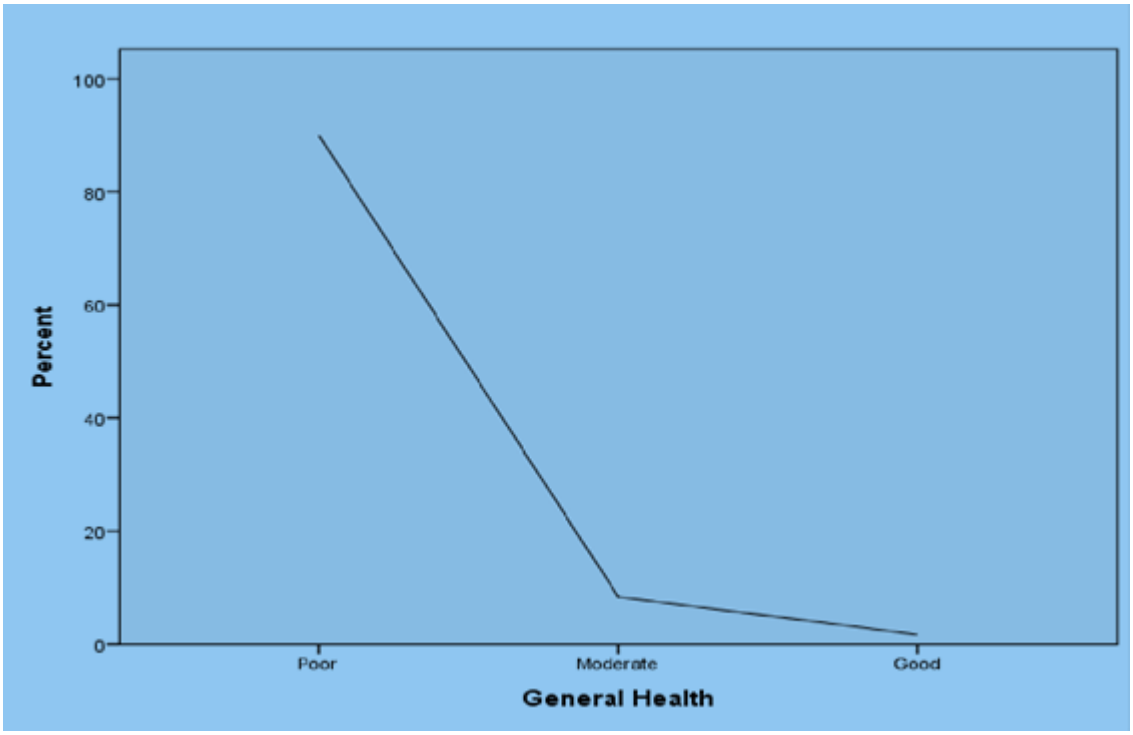

Figure 4-1: Overall Quality of Life related to General Health

Table 4-2-3. Quality of life -related to Physical Health.

List	Physical Health Items	Responses	Freq.	%	*MS±SD*	*Ass.*
1	* Physical pain preventing you from getting your work done?	Never	19	15.8	*1.97±0.541*	*Moderate*
		Sometime	85	70.8		
		Always	16	13.3		
		Total	120	100.0		
2	*Do you need any medical treatment to function in your daily life?	Never	15	12.5	*2.09±0.579*	*Moderate*
		Sometime	79	65.8		
		Always	26	21.7		
		Total	120	100.0		
3	*Do any difficulties in movement affect your way of life?	Never	26	21.7	*2.02±0.679*	*Moderate*
		Sometime	65	54.2		
		Always	29	24.2		
		Total	120	100.0		
4	Do you have enough energy for daily life?	Never	97	80.8	*1.20±0.422*	*Poor*
		Sometime	22	18.3		
		Always	1	.8		
		Total	120	100.0		
5	Satisfied with your sleep?	Never	95	79.2	*1.27±0.579*	*Poor*
		Sometime	17	14.2		
		Always	8	6.7		
		Total	120	100.0		
6	Satisfied with your ability to perform your daily living activities?	Never	101	84.2	*1.22±0.557*	*Poor*
		Sometime	11	9.2		
		Always	8	6.7		
		Total	120	100.0		
7	Satisfied with your capacity for work	Never	106	88.3	*1.17±0.513*	*Poor*
		Sometime	7	5.8		
		Always	7	5.8		
		Total	120	100.0		

** negative item*

In terms of statistical mean and standard deviation, this table demonstrated that the elderly people expressed a poor response regards physical health status as indicated by low mean scores at all studied items except, the elderly people expressed a moderate level related to " *Physical pain preventing you from getting your work done, need medical treatment*

to function in daily life and difficulties in movement affect the way of life" as indicated by moderate mean scores.

Table 4-2-4: Overall Quality of Life-related to Physical Health among Elderly People with Cardiovascular Diseases

Physical Health	Freq.	%	*M ± SD*
Poor	75	62.5	
Moderate	44	36.7	*10.96±1.869*
Good	1	0.8	
Total	120	100.0	

M: Mean (total score), SD=Standard Deviation (total score)

(*Poor= 7-11; Moderate=12-16; Good=17-21*)

The findings illustrated that the (62.5%) of elderly people with cardiovascular diseases exhibited a poor quality of life associated with physical health at Mean and (±SD) = *10.96* (*±1.869*).

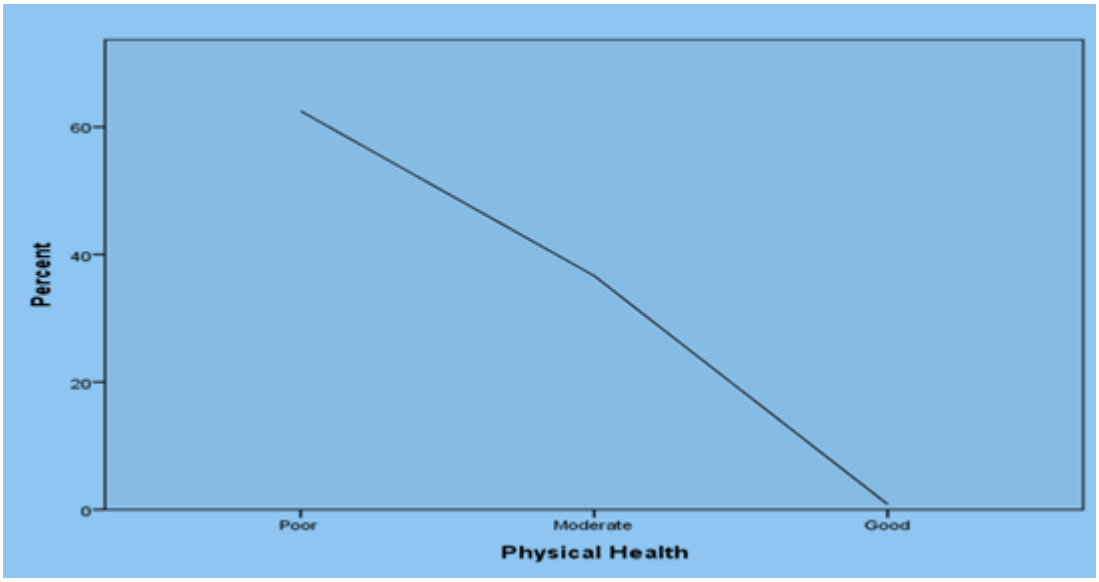

Figure 4-2: Quality of Life related to Physical Health

Table 4-2-5. Quality of life -related to Psychological Health

List	Psychological Health Items	Responses	Freq.	%	*MS±SD*	*Ass.*
1	How much do you enjoy life?	Never	69	57.5	*1.61±0.790*	*Poor*
		Sometime	28	23.3		
		Always	23	19.2		
		Total	120	100.0		
2	Do you feel your life is meaningful?	Never	54	45.0	*1.80±0.822*	*Moderate*
		Sometime	35	29.2		
		Always	31	25.8		
		Total	120	100.0		
3	How well are you able to concentrate and memorize?	Never	55	45.8	*1.68±0.709*	*Moderate*
		Sometime	48	40.0		
		Always	17	14.2		
		Total	120	100.0		
4	Satisfied with your appearance?	Never	46	38.3	*1.92±0.831*	*Moderate*
		Sometime	37	30.8		
		Always	37	30.8		
		Total	120	100.0		
5	Are you satisfied with yourself?	Never	31	25.8	*2.20±0.829*	*Moderate*
		Sometime	33	27.5		
		Always	56	46.7		
		Total	120	100.0		
6	*How often do you have negative feelings such as blue mood, despair, anxiety, or depression?	Never	19	15.8	*1.90±0.467*	*Moderate*
		Sometime	93	77.5		
		Always	8	6.7		
		Total	120	100.0		

** negative item*

In terms of statistical mean and standard deviation, this table demonstrated that the elderly people expressed a moderate response regards psychological health status as indicated by moderate mean scores at all studied items except, the elderly people expressed a poor response to "*enjoyment in life*" as indicated by low mean scores.

Table 4-2-6: Overall Quality of Life-related to Psychological Health among Elderly People with Cardiovascular Diseases.

Psychological Health	Freq.	%	*M ± SD*
Poor	52	43.3	
Moderate	59	49.2	*11.15±2.052*
Good	9	7.5	
Total	120	100.0	

M: total score Mean, SD=total score Standard Deviation

(*Poor= 6-10; Moderate=11-14; Good=15-18*)

The findings illustrated that the (49.2%) of elderly people with cardiovascular diseases exhibited a moderate quality of life associated with psychological health at Mean and (±SD) = *11.15* (*±2.052*).

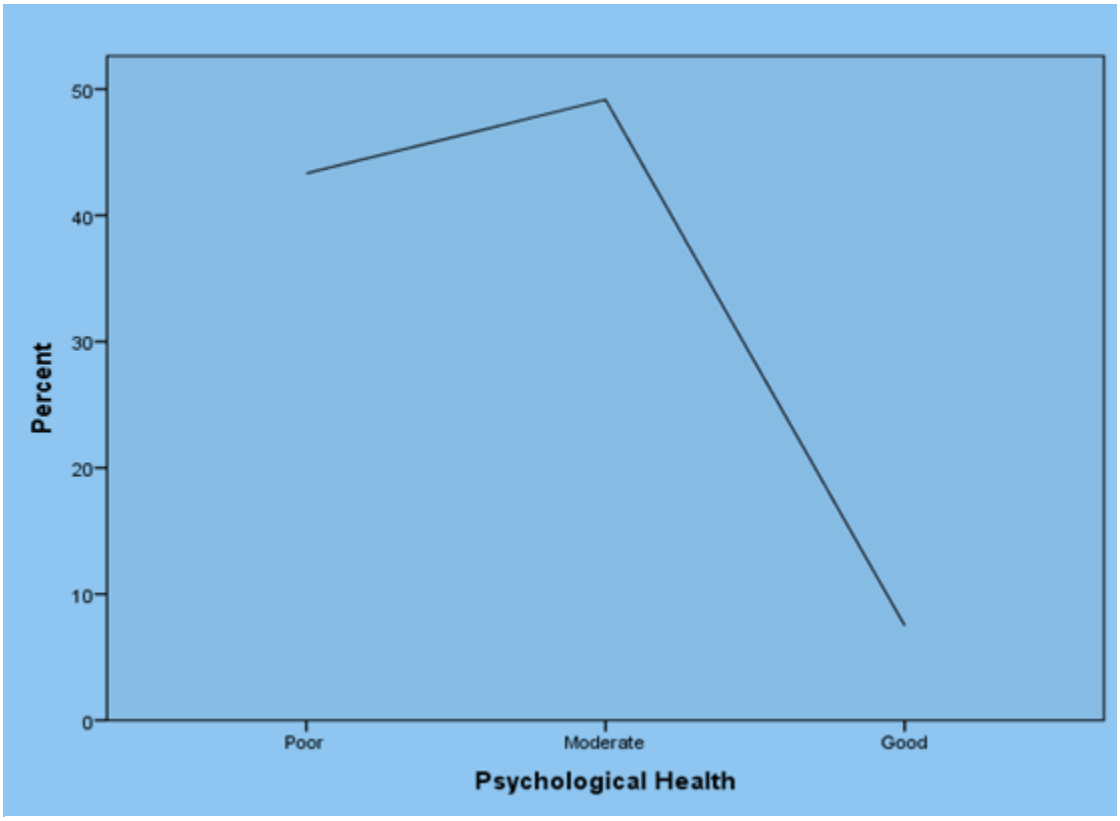

Figure 4-3: Quality of Life related to Psychological Health

Table 4-2-7. Quality of life related to Environment Health

List	Environmental Health Items	Responses	Freq.	%	*MS±SD*	*Ass.*
1	Your physical environment is healthy?	Never	76	63.3	*1.45±0.659*	*Poor*
		Sometime	33	27.5		
		Always	11	9.2		
		Total	120	100.0		
2	Have you enough money to meet your needs?	Never	67	55.8	*1.55±0.695*	*Poor*
		Sometime	39	32.5		
		Always	14	11.7		
		Total	120	100.0		
3	Is there the information you need in your daily life?	Never	54	45.0	*1.61±0.610*	*Poor*
		Sometime	58	48.3		
		Always	8	6.7		
		Total	120	100.0		
4	Do you have the opportunity for leisure activities?	Never	67	55.8	*1.53±0.660*	*Poor*
		Sometime	42	35.0		
		Always	11	9.2		
		Total	120	100.0		
5	How safe do you feel in your daily life?	Never	69	57.5	*1.55±0.708*	*Poor*
		Sometime	36	30.0		
		Always	15	12.5		
		Total	120	100.0		
6	satisfied with your housing conditions??	Never	47	39.2	*1.91±0.835*	*Moderate*
		Sometime	36	30.0		
		Always	37	30.8		
		Total	120	100.0		
7	Satisfied with your access to health services?	Never	81	67.5	*1.40±0.627*	*Poor*
		Sometime	30	25.0		
		Always	9	7.5		
		Total	120	100.0		
8	Satisfied with your transport?	Never	63	52.5	*1.54±0.620*	*Poor*
		Sometime	49	40.8		
		Always	8	6.7		
		Total	120	100.0		

In terms of statistical mean and standard deviation, this table demonstrated that the elderly people expressed a poor response as regards the environmental health as indicated by low mean scores at all studied items except, the elderly people expressed a moderate response to "*satisfied*

with the conditions of living place" as indicated by moderate mean scores.

Table 4-2-8: Overall Quality of Life-related to Environmental Health among Elderly People with Cardiovascular Diseases.

Environmental Health	Freq.	%	*M ± SD*
Poor	80	66.7	*12.57±3.296*
Moderate	33	27.5	
Good	7	5.8	
Total	120	100.0	
M: total score (Mean), SD= total score (Standard Deviation) (*Poor= 8-13; Moderate=14-18; Good=19-24*)			

The Findings illustrated that the (66.7%) of elderly people with cardiovascular diseases exhibited a poor quality of life associated with environmentalat Mean and (±SD) = *12.57* (*±3.296*).

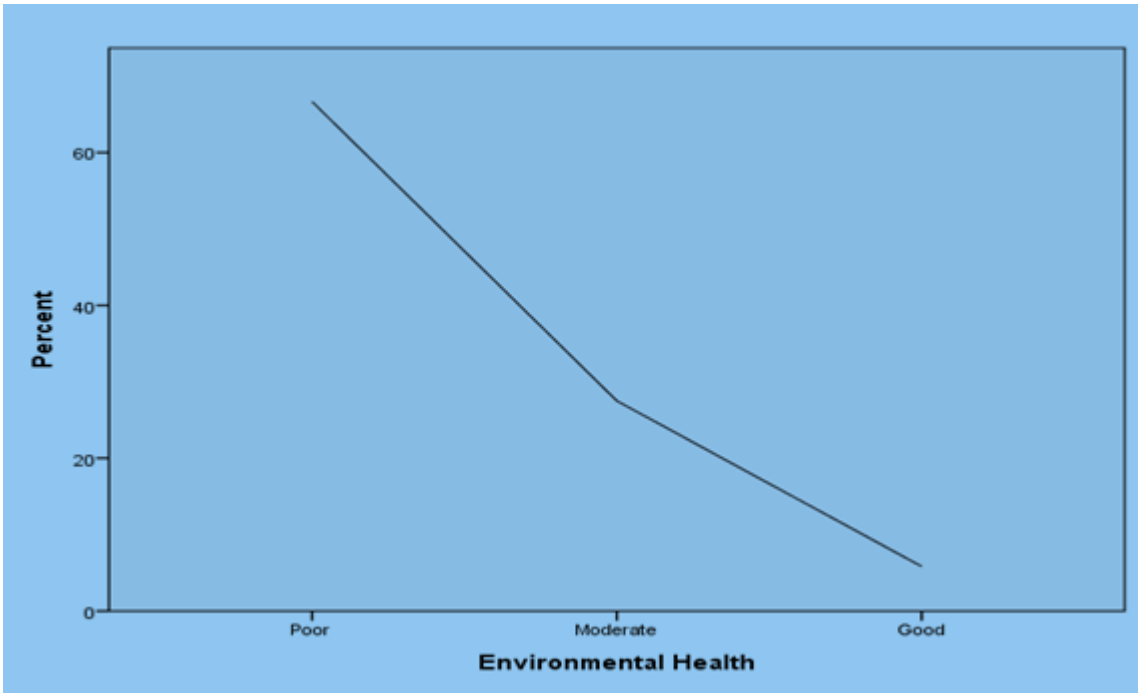

Figure 4-4: Quality of Life related to Environmental Health

Table 4-2-9 Quality of life -related to Social Relationship

List	Social Relationship Items	Responses	Freq.	%	*MS±SD*	*Ass.*
1	Satisfied with your relationships?	Never	5	4.2	*2.56±0.575*	*Good*
		Sometime	42	35.0		
		Always	73	60.8		
		Total	120	100.0		
2	Satisfied with the support you receive from your family	Never	2	1.7	*2.82±0.423*	*Good*
		Sometime	17	14.2		
		Always	101	84.2		
		Total	120	100.0		
3	Satisfied with the support you get from your friends?	Never	6	5.0	*2.66±0.570*	*Good*
		Sometime	28	23.3		
		Always	86	71.7		
		Total	120	100.0		

In terms of statistical mean and standard deviation, this table demonstrated that the elderly people expressed a good response to a social relationship as indicated by higher mean scores in all studied items.

Table 4-2-10: Overall Quality of Life-related to Social Relationship among Elderly People with Cardiovascular Diseases

Social Health	Freq.	%	*M ± SD*
Poor	5	4.2	*8.05±1.218*
Moderate	25	20.8	
Good	90	75.0	
Total	120	100.0	

M: total score for Mean, SD= total score for Standard Deviation

(*Poor= 3-5; Moderate=6-7; Good=8-9*)

The findings illustrated that the (75%) of elderly people with cardiovascular diseases exhibited a good quality of life associated with a social relationship at a Mean and (±SD) = *8.05* (*±1.218*).

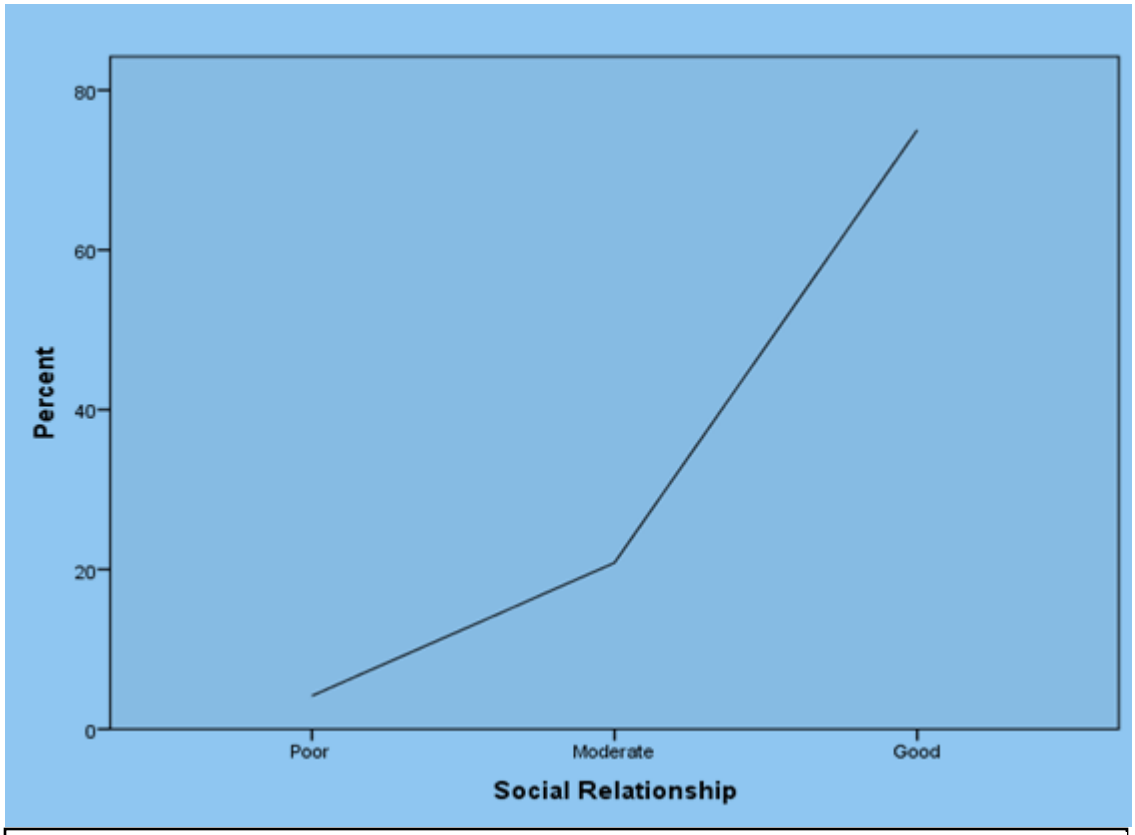

Figure 4-5: Quality of Life related to Social Relationship

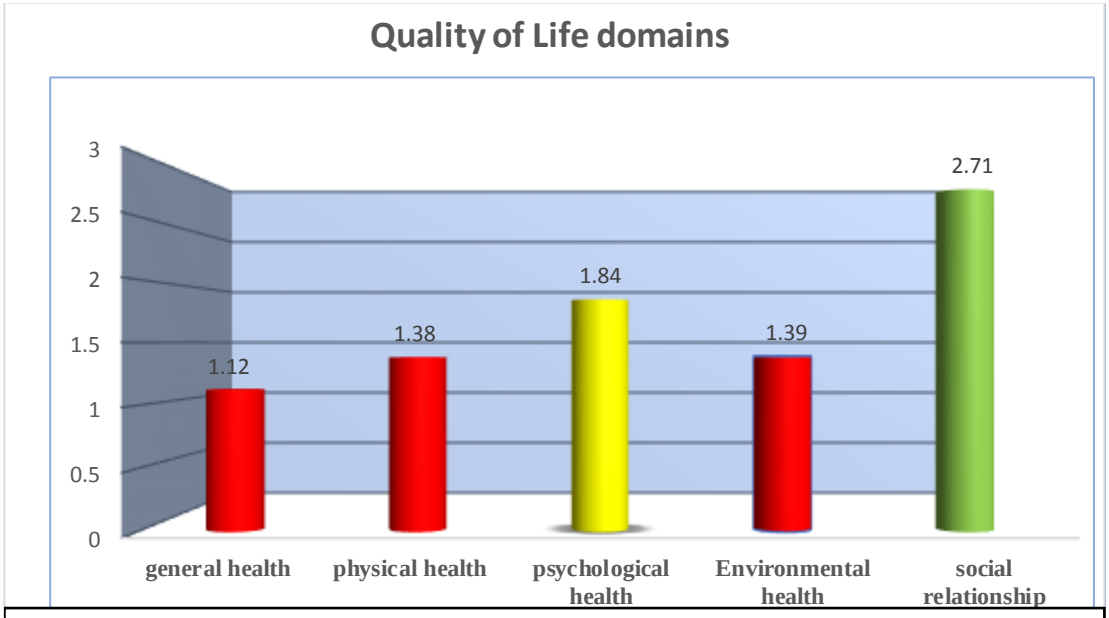

Figure 4-6: Quality of Life according to Domains

The findings in the figure (4-6) showed the quality of life profile according to mean that general health (*M=1.12*) was the most common associated poor quality of life, followed by physical health (*M=1.38*), followed by environmental health (*M=1.39*). the psychological health has moderate mean score (*M=1.85*). as well as, the social health which records the highest mean score (*M=2.71*) as a good quality related to social health.

4-2-11: Table overall Quality of Life among Elderly People with Cardiovascular diseases

Quality of Life	Freq.	%	*M ± SD*
Poor	53	44.2	
Moderate	67	55.8	*51.66±4.981*
Total	120	100.0	

M: total score (Mean), SD= total score (Standard Deviation)

(*Poor= 30-50; Moderate=51-70; Good=71-90*)

The findings illustrated that the (55.8%) of elderly people with cardiovascular diseases exhibited a moderate quality of life *51.66±4.981*

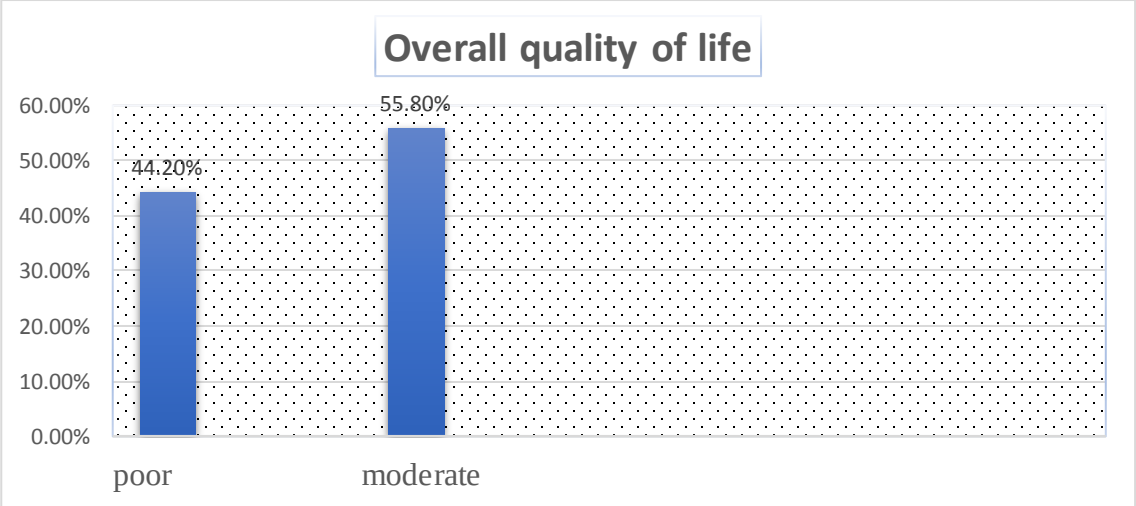

Figure 4-7: Overall Quality of Life

4.3. Relationship between Quality of Life and Elderly Socio-demographic Characteristics

Tables 4-3. Significant Relationship between Quality of Life and Elderly Socio-demographic Characteristics

SDVs	χ^2 Value	D.f	P-Value	
Age/years	**5.640**	**2**	**0.020**	**N.sig**
Gender	**0.020**	**1**	**0.888**	**N.sig**
Marital status	**0.670**	**2**	**0.715**	**N.sig**
Education level	**3.383**	**3**	**0.336**	**N.sig**
Occupation	**17.084**	**3**	**0.001**	**sig**
Socio-economic	**13.457**	**2**	**0.001**	**sig**
Residents	**4.089**	**1**	**0.043**	**sig**

"χ^2 = Chi-square, Df= Degree of freedom, P-value= Probability value, S= significant, NS= non-significant"

This table indicate that there was relationship between quality of life among elderly and their age (p=0.020**)**, occupation (p=0.001), socio-economic status (p=0.001) and residents (p=0.043).

Chapter Five

Discussion

Chapter Five

Discussion of result study

This chapter presents a detailed discussion. The researcher delves into the meaning, importance and relevance of the results and focuses on explaining and evaluating those results. They also show the extent to which they are related to previous studies and their consistency with other sections of the study. The discussion section gives the researcher a valuable opportunity to present evidence that will support and strengthen his hypotheses and conclusions, focusing on the analysis and interpretation of the study findings, with relevance to the study objectives and is arranged in the following pattern:

5.1. The Sociodemographic Characteristic of the Elderly People with cardiovascular diseases.

The present study assesses the Quality of Life for Elderly People with Cardiovascular Diseases. The Elderly People age selected with the specification of above 60 years old, since this age are very important period because Elderly life, or the period of aging, has many essential features including its link to life, to itself, that is, its unique characteristics and to society, as well as its attractiveness in general. Aging is characterized by the increase of a wide spectrum of cellular and molecular damage over time on a biological level. This causes a progressive reduction in cognitive functioning as well as a greater risk of disease and, finally, death. Aging is frequently linked to other life stages, such as retirement.

Through finding an overview of the current study, the demographic characteristically of the samples shows that the majority of Elderly People with Cardiovascular Diseases participating in the sample represents (72.5%) are between the ages of 60-69 years. this result is consistent with the results of studies carried out in Tabriz City in Iran which carried the

title (Cardiovascular Disease Patient's Quality of Life in Tabriz City in Iran) in 2018, where the majority of participants (about 80%) were between the ages of 50 and 69 years (Azami-Aghdash et al., 2019).

While the results of the sample show that the majority of the participants were female (51.7%). the results of the study not similar to the results of the research that was achieved in 2014, which was titled, (Quality of Life of People with Cardiovascular Disease: A Descriptive Study), which was conducted by Renata Komalasaria, Nurjanahb, and Maria M. Yochec in Indonesia, and was Study results The majority of the participants were male (55.4%) (Komalasari et al., 2019). The risk of Cardiovascular Disease in women goes up with age. It is the greatest cause of mortality in women over the age of 40, particularly following menopause. The reduction of natural estrogen as women age may contribute to the increased risk of CVD found after menopause. Other factors that may increase the risk of heart disease include changes in the blood vascular endothelium, modifications in the quantity of lipids in the blood, and changes in fibrinogen levels (Garcia et al., 2016).

The marital status of the sample is shown the majority of the sample is married (84.2 %). where another element of samples is single and Widower that result is agreeing with the result of a study that achieves in Indonesia year 2019, the result was married (72.5%) of a sample (Komalasari et al., 2019) and in Tabriz City in Iran in 2018, the result was married ((70.6%)) of a sample (Azami-Aghdash et al., 2019).

Regarding the level of education; the uppermost of the study sample graduated from Elementary school has (43.3%). this result agrees with the result the research achieve in 2014in Baghdad city (32.0%) (Mousa et al., 2014).

The residential status in a sample is shown a majority of samples (80%).is lived in an urban area, the results agree with the study done in 2017 in Kirkuk city show the same result where most of the participants live in urban areas which were consist of ((59.0%)of the total sample (Mohammed, 2017).

The socio-economic level of most elderly People with Cardiovascular Diseases has an Insufficient economic status (45.0 %), the results agree with the result of research that doing in the year 2018 in Dhaka, Bangladesh that appears most (52%) were in the low-income category (Barua et al., 2018).

Therefore, (Rawaf et al., 2014) showed in study about Iraqi life conditions, the Iraq's economic development is subject to oil price and volume shocks due to a lack of economic diversification. This puts at risk its capacity to implement credible and long-term budgetary policies. Economic diversification is thus a problem for the Iraqi government, both in terms of job creation and promoting income-generating options for the majority of the Iraqi population.

5.2. Discussion Medical History of the Elderly People with Cardiovascular Diseases.

The medical history of the sample revealed findings, that most people had a history of coronary artery diseases (47.5%). Coronary artery disease is the largest cause of premature death and suffering globally, and has been for decades, although with significant regional variation. While actual numbers with CAD continue to increase. Over the last 27 years, the number of people diagnosed with CAD has grown. This rise in Cardiovascular diseases a load has serious implications for the capacity and planning of healthcare systems. A program centered on delivering tertiary cardiac care,

in particular, may be unsustainable in the absence of a matching emphasis on preventive and primary care (Khan et al., 2020).

The majority of those involved in the search appeared duration of the disease be more than 2 years with the disease. This result is opposite to a study in Tabriz in Iran 2019 that revealed the duration of affliction was 6 to 12 months in most participants (Azami-Aghdash et al., 2019). Cardiovascular disease is a chronic disease with a significant and frequently deadly acute manifestation. Despite improvements in lowering mortality, over 2.7 million people in the UK have coronary heart disease (CHD).

The majority of individuals (52.5 %) were elderly People with Cardiovascular Conditions who did not have any chronic diseases. this study disagrees with a study in Kirkuk City shows tow-third of the patients had chronic diseases (Mohammed, 2017).

5.3. Discussion of Quality of life-related to General Health Items.

The findings showed that the majority (90%) of elderly people with cardiovascular diseases had a poor quality of life associated with general health. A similar study in Saudi Arabia found that the lowest mean score was for General Health (General perception about health), indicating that the patients had a poor QoL (AbuRuz et al., 2015). and also study in Bahia in Brazilian have lowered the quality of life in the general health state (Haluzíková & Jabůrková, 2020).

What the researcher revealed is, due to Patients suffering from various cardiovascular diseases may have symptoms such as dyspnea, edema, sleeping difficulties, depression, and chest discomfort, with breathlessness being the most prevalent. These symptoms make it difficult for individuals to maintain a high quality of life.

5.3.2. Discussion of Quality of life-related to Physical Health Items.

The findings revealed that 62.5% of individuals with cardiovascular illnesses had a low quality of life-related to physical health. This report concurs with a survey conducted in Indonesia in 2019 that found (54.7%) have a low quality of life in terms of physical health (Komalasari et al., 2019).Furthermore, the study results were not supported by data revealing that the physical functioning, Role physical had a Moderate, high quality of life in study in Baghdad city 2014 (Mousa et al., 2014).

Poor physical quality of life in People with CVD It is generally due to poor physical condition, lack of enough energy to work and difficulty managing body weight, getting regular exercise, following a heart-healthy diet, and quitting smoking.

. 5.3.2. Discussion Quality of Health related to Psychological Health.

The elderly had a moderate response in terms of psychological health state, as evidenced by moderate mean scores. This research's findings align with a 2014 study named (Patients' Health-Related Quality of Life After Percutaneous Coronary Intervention in Baghdad City), which found that psychological health has a moderate quality of life (Mousa et al., 2014).

From the researcher's point of view, the above may be due to Millions of individuals throughout the world having had traumatic experiences as a result of war and conflict, economic crises, and displacement. While such events have an impact on the mental health of any society, the psychological well-being of people in humanitarian situations is rarely studied. Prolonged and exacerbated trauma is a reality in Iraq.

. 5.3.4. Discussion Quality of Health related to Environment Health.

Poor quality of life associated with environmental health was revealed in this study at 66.7%, which is comparable to the study titled (Quality of Life of People with Cardiovascular Disease: A Descriptive Study), which revealed an inadequate quality of life associated with environmental health at 85.1% (Komalasari et al., 2019).

The researcher adds more details about environmental conditions and quality of life of older persons. The environment is a wide word that incorporates buildings, places, and objects that are constructed or modified by humans as a health factor. environmental variables have been added to the "International Classification of Functioning, Disability, and Health" as determinants of health and disability (ICF). In addition to that the housing conditions in Iraq are in a dire state for the majority of the population. This suggests that finding sufficient shelter is difficult for both internally displaced individuals and host groups. also, Years of violence and sanctions have resulted in neglect of Iraq's transportation infrastructure; as a result, the roads are in poor shape and poorly maintained. The lack of operational traffic signals, pedestrian crossings, road markings, road signs, and speed restrictions makes driving in urban areas and on highways dangerous.

Iraq's health services are trying to regain lost support after decades of conflict, sanctions, and occupation. Many competent health workers have relocated to other countries, and fresh graduates are still leaving. Despite the extensive reconstruction, healthcare infrastructure has not been entirely restored. National development plans aim for a reorganization of the healthcare system, with primary health care serving as the foundation.

Nonetheless, the healthcare system remains centralized and concentrated on hospitals (Al Hilfi et al., 2013)

.5.3.5. Discussion Quality of Health-related to Social Relationship.

This study found that elderly individuals had higher mean scores on all studied items as good responses to social relationships. this finding agrees with a study In Baghdad City 2014 shows social functioning has a high quality of life (Mousa et al., 2014)

Positive experiences in social relationships, such as support, closeness, and companionship, have been related to improved mental and physical health. However, social connections can have a negative impact on health and mortality risk by causing conflict, alienation, and support costs. Given the 'double-edged' character of social connections, it is critical to understand how these aspects alter with age.

5.4. Relationship between Quality of Life and their demographic data.

There was significant relation in quality of life between older adults with cardiovascular disorders and their age groups. according to the findings. As previously stated, the current study agrees with a study conducted in the southern region of West Bengal, India. This demonstrates that as one becomes older, one's quality of life deteriorates significantly (Datta et al., 2015)

The researcher explained with a person's age rises health-related issues become increasingly frequent. Gradually, people's ability to work diminishes, and they become increasingly restricted to their own homes. Loneliness is a prevalent issue in this setting. The likelihood of losing a partner increases with age. Loneliness grows significantly in the circumstance. As a result, as people get older, their physical and

psychological quality of life deteriorates. Aside from that, social interaction declines with age.

There was significant relationship in the quality of life between older adults with cardiovascular illnesses and their employment. We see that those who work for free have a lower quality of life than others. The result of the study disagrees with the study's revealing that there is no significant difference in all domains of quality of life regarding the patient's occupation (Mohammed, 2017)

According to a Swedish study of elderly persons. Occupational balance was explored for older employees aged 65 and higher. As a consequence, it was discovered that individual skills, use of community resources, harmonic concord with one's employment, and personal values and unity all contribute to attaining a healthy occupational balance. As a result, it is vital to encourage older adults to find significance in social activities rather than focusing solely on tasks at home such as hygiene management, rest, and good food (Hovbrandt et al., 2019).

The findings revealed that there was significant relationship in quality of life and economic status among elderly people with cardiovascular illnesses. It has been noticed that persons with minimal economic resources have a much lower quality of life according to the findings of a study conducted in Tabriz, Iran in 2018, there is a significant association between economic status (income) and QOL (Azami-Aghdash et al., 2019).

The elderly is a socially engaged demographic that should not be ignored. As a result, effective employment promotion policies must be adopted to promote the elderly's economic activity. Economic activities of the elderly are a significant role in satisfying their different aspirations, such as reducing poverty, enhancing the quality of life, and encouraging

daily living and health activities. Low income, poor health, and the prevalence of geriatric illnesses are all key variables influencing access to health insurance and medical care support (Kim et al., 2017).

The findings revealed that there was significant relationship in quality of life between urban and rural elderly persons with cardiovascular illnesses. The majority of people in rural areas were connected with a low quality of life. This study, which is comparable to one conducted in Wolaita Zone Governmental Hospitals in Southern Ethiopia in 2020, found the residence to be a statistically significant factor linked with the overall score of HRQoL and poor quality of life-related to heart failure in rural areas (Molla et al., 2021).

The American Heart Association presidential advice underscores the critical need to better study and treats rural health inequalities. Rural citizens in the United States die at a higher rate than their urban counterparts. Americans living in rural locations, in particular, are more likely to die from the five major causes of mortality, including heart disease, than those living in metropolitan areas. Rural locations had a larger number of cigarette smokers, obesity, and sedentary behavior, as well as worse survival after diabetes mellitus and coronary heart disease diagnosis. While the specific mechanism for these relationships is unknown, patients in rural locations may face greater hurdles to care due to factors such as healthcare worker shortages and facility closures (Manemann et al., 2021).

Finally, In the past decade, there has been a considerable increase in chronic diseases due to absence various factors including improved living conditions, better prevention, handling of infectious diseases, medical technologies, and general aging of the population. Therefore, there are numerous people living with chronic diseases that can influence their QoL. Chronic diseases can cause limited living capacity, limited performance,

fertility and QoL, as well as increased health costs. Assessment of the QoL can help promote the treatment, care, and rehabilitation programs for patients.

Chapter Six

Conclusions

&

Recommendations

Chapter six

Conclusions and Recommendations

This chapter presents the conclusions which are derived from the interpretation and discussion of the findings. The recommendations are based on the study conclusions.

6.1. Conclusions

This study was conducted with 120 respondents to identify the quality of life of the elderly in Teaching hospitals in al-Hilla city using the WHOQOL-BREF questionnaire modified by the researcher and supervisors. The results showed that:

1.The majority of Elderly People with Cardiovascular Diseases participating in the study between the ages of 60-69 years were female and mostly of the sample are married. Regarding the level of education; the uppermost of the study sample graduated from Elementary school. The residential status in a sample show that the majority of samples lived in an urban area. The socio-economic level of most of them has an Insufficient economic status.

2. The medical history of the sample revealed that most people had a history of coronary artery diseases and duration of the disease is more than 2 years with the disease. The majority of individuals were elderly People with Cardiovascular Conditions who did not have any chronic diseases.

3. Elderly people with cardiovascular diseases had exhibited a moderate overall quality of life. a poor quality of life associated with general health, physical health, environmental health while had a moderate response in terms of psychological health state, as evidenced by moderate mean scores.

The elderly individuals had higher mean scores on all studied items as good responses to social relationships.

4. There were no significant relationship in quality of life among elderly people with cardiovascular disorders and Patients Gender, Marital Status, Education Level.

5. There were significant relationship in quality of life between older adults with cardiovascular disorders and their age groups, employment, economic status, Resident elderly persons.

6.2. RECOMMENDATIONS

1. developing of educational programs can encourage a healthy body weight, regular physical activities to improve patient life adaptability, and psycho-social support.

2. Providing psychological therapies (such as relaxation, stress management, and cognitive coping skills) to assist people with cardiovascular problems in adjusting to their illness.

3. Handing out pamphlets with information on cardiovascular problems, home exercise routines, and counseling to patients

4. Healthy lifestyles, self-management, and daily activities to improve health outcomes in cardiovascular disease patients.

5. Doing more research to identify needs of elderly people with cardiovascular diseases that decrease the complications and burden of this disease.

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القرأن الكريم :سورة الاسراء الاية 23

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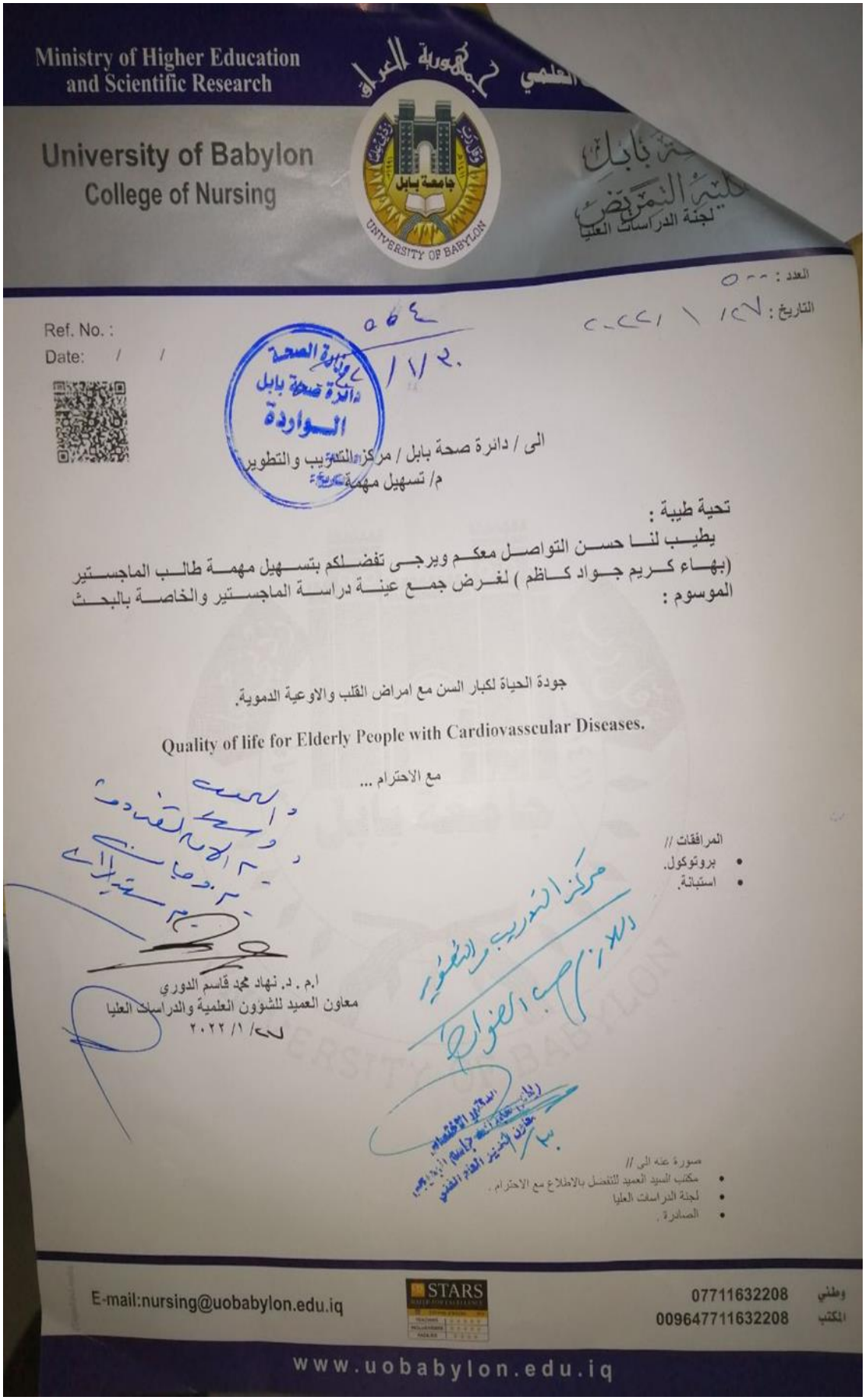
Appendices

Appendix A



Ministry of Higher Education and Scientific Research

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University of Babylon
College of Nursing

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UNIVERSITY OF BABYLON

جامعة بابل
كلية التمريض
لجنة الدراسات العليا

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التاريخ : ٢٠٢١ / ١ / ٢٧

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Date: / /

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الى / دائرة صحة بابل / مركز التدريب والتطوير
م/ تسهيل مهمة

تحية طيبة :

يطيب لنا حسن التواصل معكم ويرجى تفضلكم بتسهيل مهمة طالب الماجستير (بهاء كريم جواد كاظم) لغرض جمع عينة دراسة الماجستير والخاصة بالبحث الموسوم :

جودة الحياة لكبار السن مع امراض القلب والاوعية الدموية.

Quality of life for Elderly People with Cardiovasscular Diseases.

مع الاحترام ...

المرافقات //
- بروتوكول.
- استبانة.

أ.م . د. نهاد محمد قاسم الدوري
معاون العميد للشؤون العلمية والدراسات العليا
٢٠٢٢ /١ /٢٠

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- لجنة الدراسات العليا
- الصادرة .

E-mail:nursing@uobabylon.edu.iq

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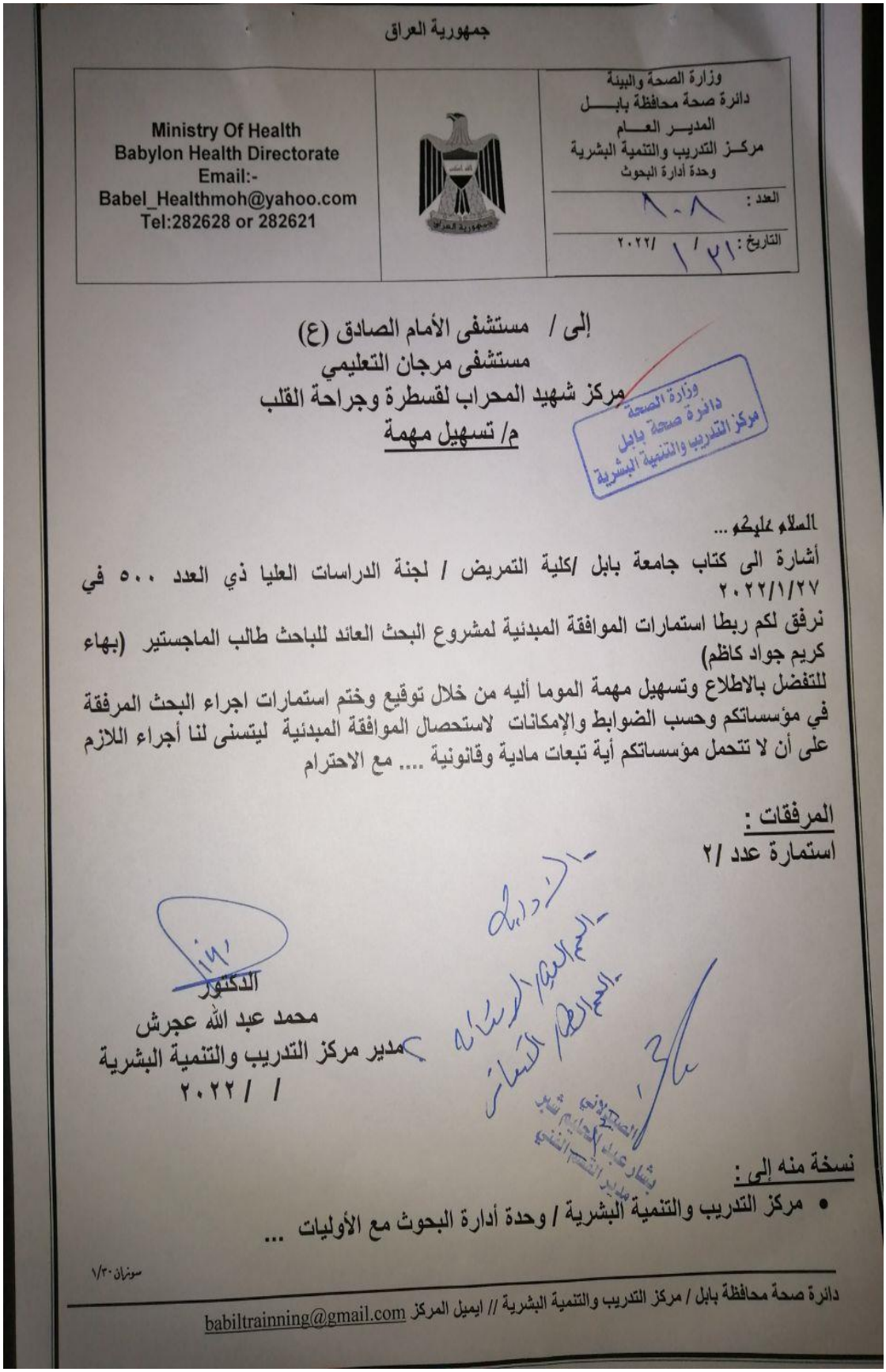
Appendix A



جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
وحدة أدارة البحوث

العدد : ٨٠٨
التاريخ : ٢٠٢٢/ ١/ ٢١

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

إلى / مستشفى الأمام الصادق (ع)
مستشفى مرجان التعليمي
مركز شهيد المحراب لقسطرة وجراحة القلب
م/ تسهيل مهمة

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

السلام عليكم ...

أشارة الى كتاب جامعة بابل /كلية التمريض / لجنة الدراسات العليا ذي العدد ٥٠٠ في ٢٠٢٢/١/٢٧

نرفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحث طالب الماجستير (بهاء كريم جواد كاظم)

للتفضل بالاطلاع وتسهيل مهمة الموما أليه من خلال توقيع وختم استمارات اجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

المرفقات :
استمارة عدد /٢

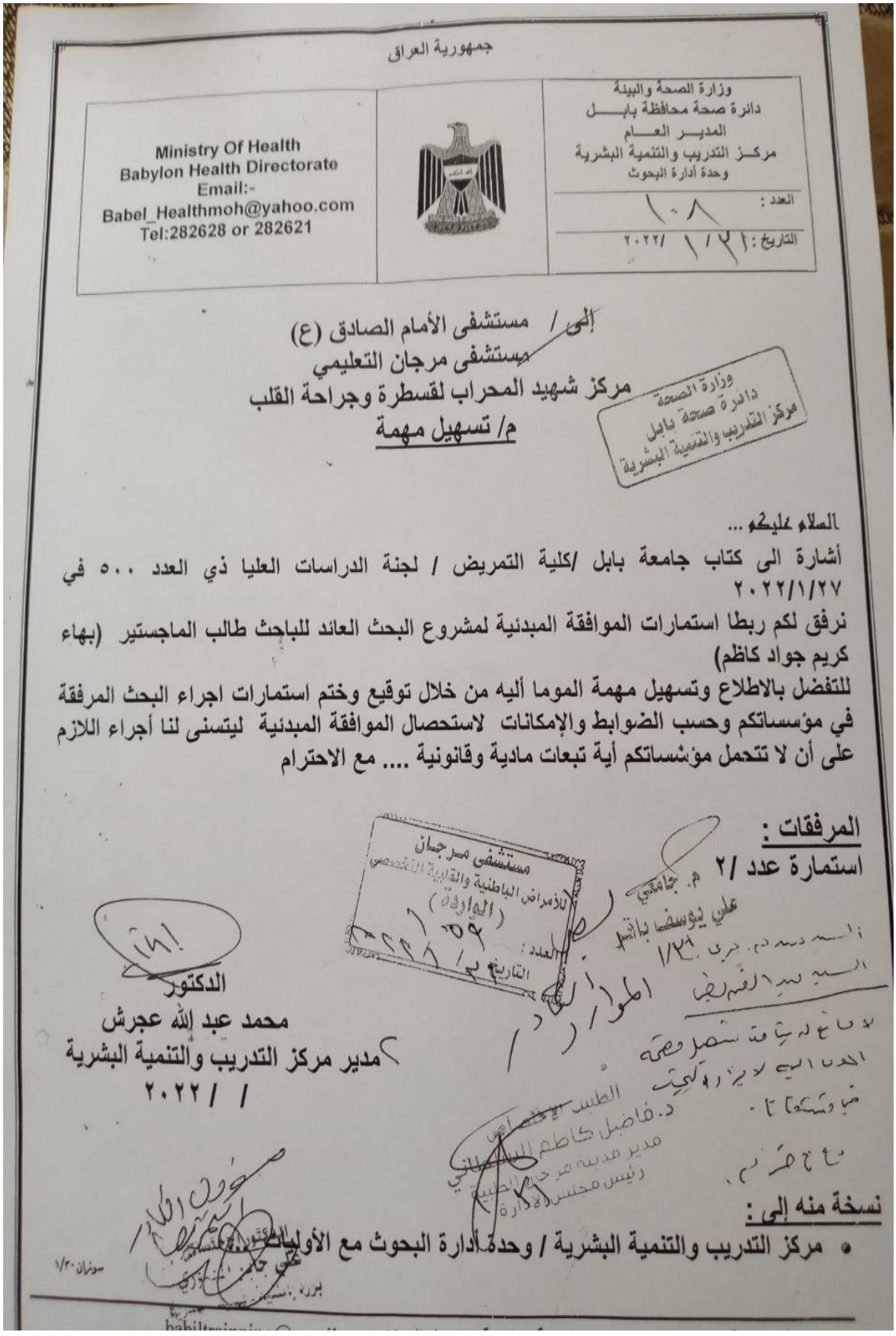
الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
/ / ٢٠٢٢

نسخة منه إلى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات ...

سونزان ١/٣٠

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltrainning@gmail.com

Appendix A



جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
وحدة أدارة البحوث

العدد : ١٠٨
التاريخ : ٢٠٢٢/ ١/ ٢١

Ministry Of Health
Babylon Health Directorate
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إلى / مستشفى الأمام الصادق (ع)
مستشفى مرجان التعليمي
مركز شهيد المحراب لقسطرة وجراحة القلب
م/ تسهيل مهمة

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية

السلام عليكم ...

أشارة الى كتاب جامعة بابل /كلية التمريض / لجنة الدراسات العليا ذي العدد ٥٠٠ في ٢٠٢٢/١/٢٧

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المرفقات :
استمارة عدد /٢

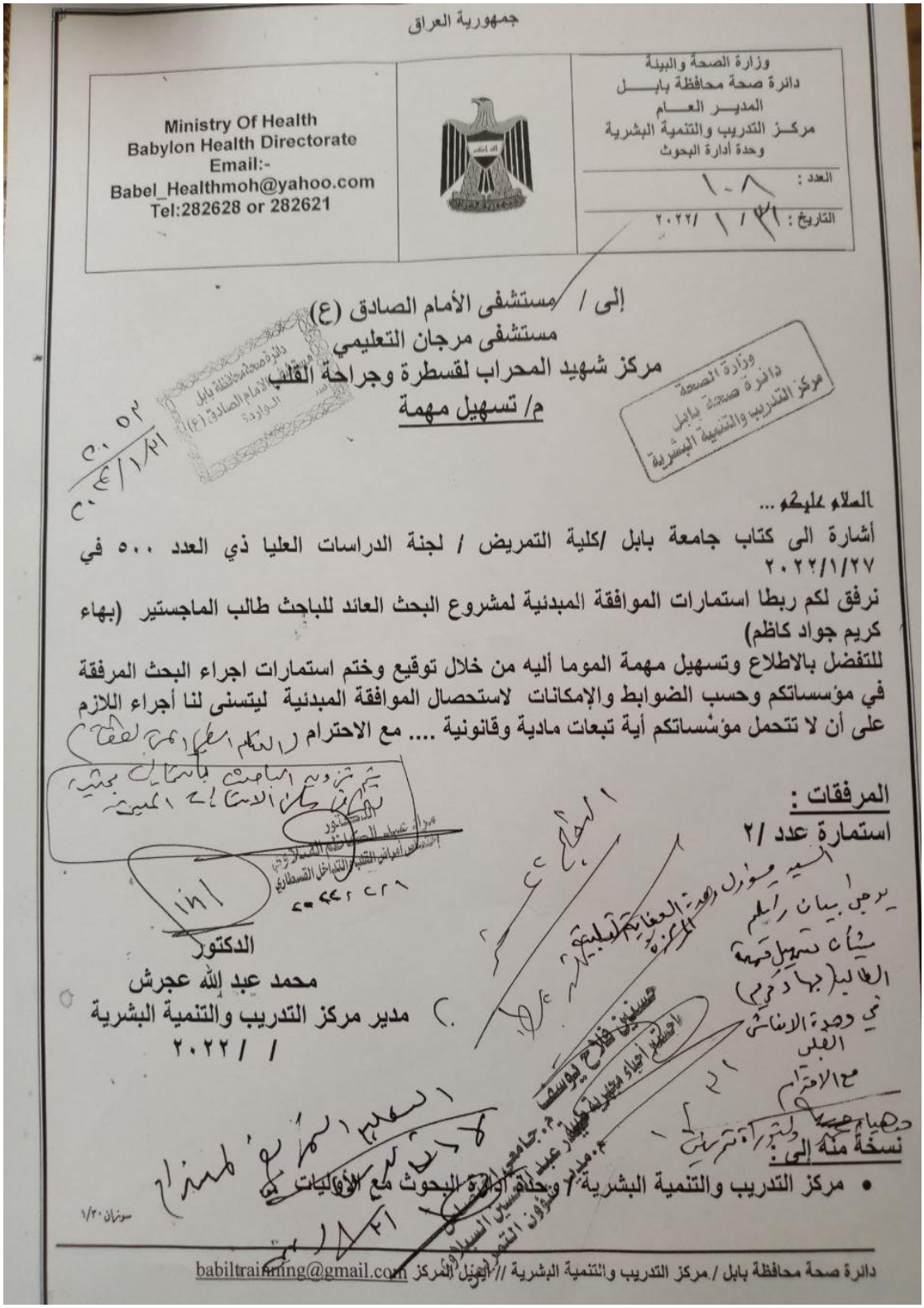
مستشفى مرجان
للأمراض الباطنية والقلبية التخصصي
(الواردة)
العدد :
التاريخ :

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
٢٠٢٢/ /

د. فاضل كاظم
مدير مدينة مرجان الطبية
رئيس مجلس الإدارة

نسخة منه إلى :
- مركز التدريب والتنمية البشرية / وحدة أدارة البحوث مع الأوليات

Appendix A



جمهورية العراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
وحدة أدارة البحوث

العدد : ١٠٨
التاريخ : ٢٠٢٢/ ١ / ٢١

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

إلى / مستشفى الأمام الصادق (ع)
مستشفى مرجان التعليمي
مركز شهيد المحراب لقسطرة وجراحة القلب
م/ تسهيل مهمة

السلام عليكم ...

أشارة الى كتاب جامعة بابل /كلية التمريض / لجنة الدراسات العليا ذي العدد ٥٠٠ في ٢٠٢٢/١/٢٧

نرفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحث طالب الماجستير (بهاء كريم جواد كاظم)

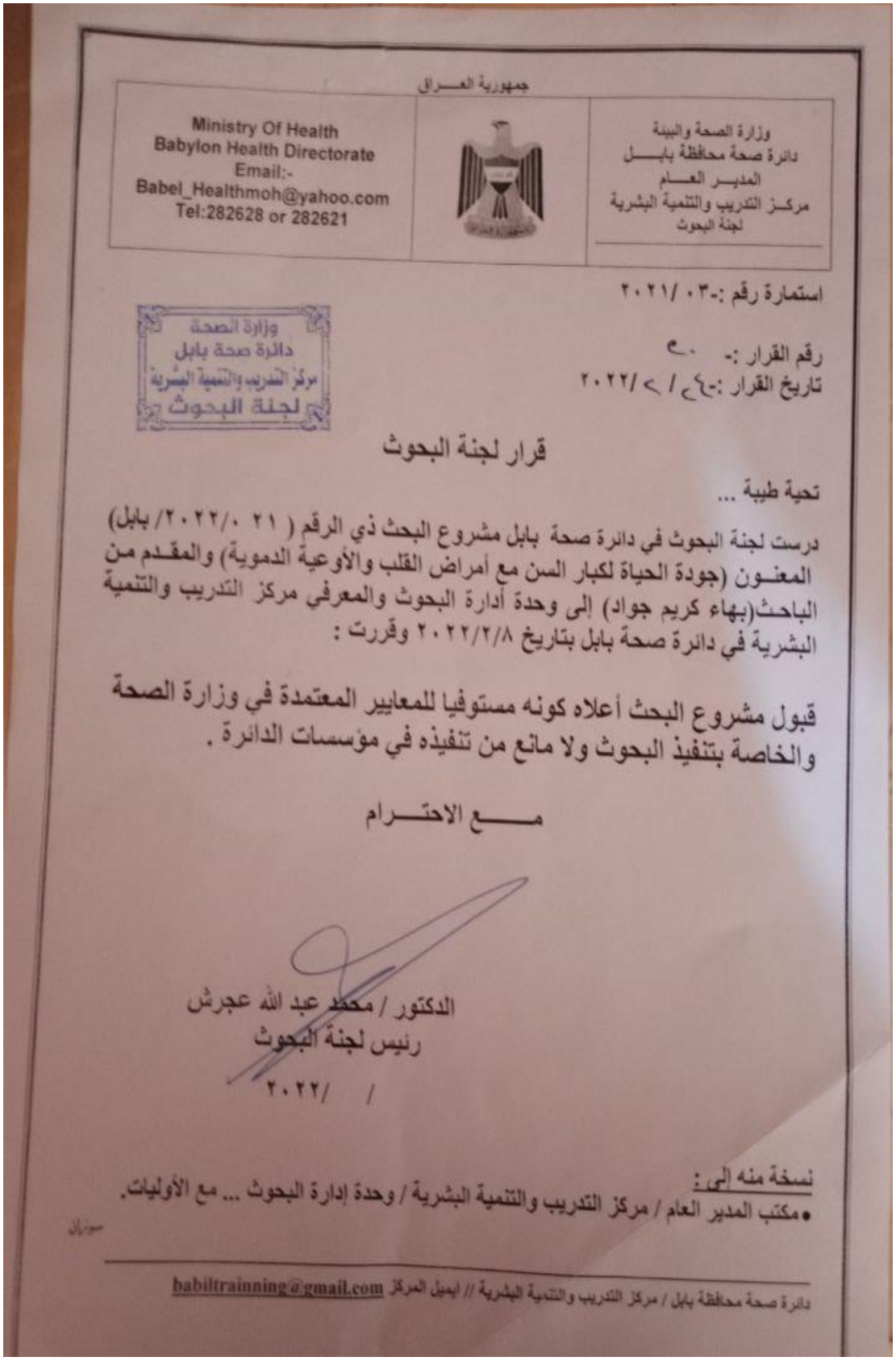
للتفضل بالاطلاع وتسهيل مهمة الموما أليه من خلال توقيع وختم استمارات اجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا أجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية .... مع الاحترام

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
٢٠٢٢/ /

المرفقات :
استمارة عدد /٢

نسخة منه إلى :
- مركز التدريب والتنمية البشرية / وحدة ادارة البحوث مع الأوليات

Appendix A



جمهورية العـــراق

وزارة الصحة والبيئة
دائرة صحة محافظة بابـــل
المديـــر العـــام
مركـــز التدريب والتنمية البشرية
لجنة البحوث

Ministry Of Health
Babylon Health Directorate
Email:-
Babel_Healthmoh@yahoo.com
Tel:282628 or 282621

استمارة رقم :-٠٣ /٢٠٢١

وزارة الصحة
دائرة صحة بابل
مركز التدريب والتنمية البشرية
لجنة البحوث

رقم القرار :- ٤٠
تاريخ القرار :-٢٤ / ٢ /٢٠٢٢

قرار لجنة البحوث

تحية طيبة ...

درست لجنة البحوث في دائرة صحة بابل مشروع البحث ذي الرقم (٢١ ٠/٢٠٢٢/ بابل) المعنـون (جودة الحياة لكبار السن مع أمراض القلب والأوعية الدموية) والمقـدم من الباحث(بهاء كريم جواد) إلى وحدة أدارة البحوث والمعرفي مركز التدريب والتنمية البشرية في دائرة صحة بابل بتاريخ ٢٠٢٢/٢/٨ وقررت :

قبول مشروع البحث أعلاه كونه مستوفيا للمعايير المعتمدة في وزارة الصحة والخاصة بتنفيذ البحوث ولا مانع من تنفيذه في مؤسسات الدائرة .

مـــــع الاحتـــرام

الدكتور / محمد عبد الله عجرش
رئيس لجنة البحوث
/ /٢٠٢٢

نسخة منه إلى :
• مكتب المدير العام / مركز التدريب والتنمية البشرية / وحدة إدارة البحوث ... مع الأوليات.

Appendix A

University of Babylon
College of Nursing
Research Ethics Committee

جـامـعة بـابـل
كـلية التمريـض
لجنة اخلاقيات البحث العلمي

Issue No:

Date: / /2022

Approval Letter

To,

Bahaa kareem Jawad altaee

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled **" Quality of Life for Elderly People with Cardiovascular Diseases**

The Following documents have been reviewed and approved:

1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision.

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.

Prof. Dr. Salma K. Jehad
Chair Committee
College of Nursing
Research Ethical Committee
18 / 01 /2022

Appendix A

السيد المعاون العلمي المحترم

السيد رئيس فرع تمريض الصحه المجتمع و تمريض الصحه النفسية المحترم

اللجنة العلمية والأخلاقيات المحترمون

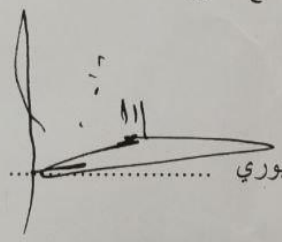
م\ اخلاقيات البحث

يرجى التفضل بالموافقة على عرض موضوع (الماجستير) على اللجنة العلمية واخلاقيات البحث العلمي عن موضوع رسالتي \ اطروحتي الموسومة باللغة العربية (جودة الحياة لكبار السن مع امراض القلب والاوعية الدموية)

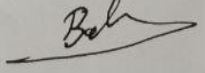
واللغة الإنكليزية

(Quality of life for elderly people with cardiovascular diseases)

مع التقدير



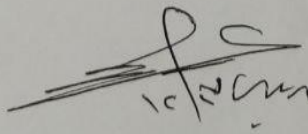
اسم المشرف الاول وتوقيعه..أ.د قحطان هادي الجبوري .....



اسم الطالب وتوقيعه بهاء كريم جواد كاظم الطائي

رئيس الفرع

رئيس الفرع وتوقيعه.....م.د. سلمى كاظم جهاد



المعاون العلمي

ملاحظة: ترفق جميع الاستمارات الخاصة بلجنة اخلاقيات البحث مع الطلب. (Ethical form 1, Ethical form2, Ethical (Form3

Appendix A

English Questionnaire

Part One: Socio-Demographic characteristics

1- Age _____ **year**

2- Gender **2.1. male** ☐ **2.2. female** ☐

3- Marital Status

3.1. single ☐ **3.2. married** ☐

3.3. divorced ☐ **3.4. widowed** ☐

4-Level of education

4.1. Illiterate ☐ **4.3. secondary school graduate** ☐

4.2. Read and write\Primary ☐ **4.4. graduate (Institute and above** ☐

5- Occupation

5.1. jobless\housewife ☐ **5. 4. Employed** ☐

5.2. free works ☐

5.3. retired ☐

6- Socio-economic status

6.1. Number of family members ☐

6.2. **Monthly Income** ☐

7. Residency (housing) 7.1. urban ☐ **7.2. rural** ☐

Part Two: Medical History

1 . Type of cardiovascular diseases

2. Duration of disease

2.1. 6 months-----1 years ☐

2.2. 1---2years ☐

2.3. 3----above ☐

3 . Chronic diseases. No ☐ **yes** ☐

Appendix A

PART Three: Quality of life Domain

	General health domain:6 items			
		Poor	Neither	Good
1	How would you rate your quality of life?			
		never	**Sometime**	**always**
2	do you have feelings of satisfaction with your health?			
3	do you worry about your health?			
4	do your personal beliefs help you to understand difficulties in life?			
5	To what extent do you feel you have control over your life?			
6	You can manage personal difficulties			
	Physical health domain:7 items			
1	Physical pain preventing you from getting your work done?			
2	do you need any medical treatment to function in your daily life?			
3	do any difficulties in movement affect your way of life?			
4	do you have enough energy for daily life?			
5	satisfied with your sleep?			
6	satisfied with your ability to perform your daily living activities?			

Appendix A

7	satisfied with your capacity for work			
Psychological health domain:6 item				
1	How much do you enjoy life?			
2	do you feel your life is meaningful?			
3	How well are you able to concentrate and memorize?			
4	Are you able to accept your body appearance?			
5	are you satisfied with yourself?			
6	How often do you have negative feelings such as blue mood, despair, anxiety, or depression?			
Environmental health domain:8				
		never	**Sometime**	**always**
1	your physical environment is healthy?			
2	Have you enough money to meet your needs?			
3	How available to you is the information you need in your day-to-day life?			
4	do you have the opportunity for leisure activities?			
5	How safe do you feel in your daily life?			
6	satisfied with the conditions of your living place?			
7	satisfied with your access to health services?			

Appendix A

8	satisfied with your transport?			
Social relationship domain :3				
		never	**Some time**	**always**
1	satisfied with your relationships?			
2	satisfied with the support you receive from your family			
3	satisfied with the support you get from your friends?			

Appendix A

Arabic Questionnaire

المحور الأول / الخصائص الاجتماعية والديموغرافية للمريض

1- العمر ☐

2- الجنس **2.1. ذكر** ☐ **2.2. أنثى** ☐

3- الحالة الاجتماعية

3.1 أعزب ☐ **3.2 متزوج** ☐

3.3 مطلق ☐ **3.4 أرمل** ☐

مستوى الوضع الاجتماعي والاقتصادي

4-مستوى التعليم

4.1. لا يكتب ولا يقرأ ☐

4.2. يكتب ويقرأ \خريج مدرسة ابتدائية ☐

4.3. خريج المدرسة الثانوية ☐ **معهد ، كلية** ☐

4.3:(ماجستير فما فوق) ☐

5- المهنة

5.1 عاطل عن العمل ☐**\ ربة منزل** ☐

5.2 أعمال حرة ☐ **متقاعد** ☐

5.3 موظف ☐

6.الحالة لاقتصادية والاجتماعية

6.1.عدد أفراد الأسرة ☐

6.2. الدخل الشهري ☐

8.الإقامة (السكن) **1.1. حضر** ☐ **1.2. ريف** ☐

المحور الثاني: التاريخ المرضي/

1- نوع مرض القلب :

2- فترة المرض

Appendix A

1.2. ستة اشهر -------سنة واحدة☐

2.2. سنة ------سنتان ☐. 3.2.. 3 سنوات -------اكثر ☐

3. امراض مزمنة:

مقياس جودة الحياة:

	مجال الصحة العامة			
		سيئة	لا بأس	جيدة
1	كيف تقيم مستوى(جودة) حياتك؟			
		ابدا	احيانا	دائما
2	راض عن ظروفك الصحية؟			
3	انت قلق على صحتك ؟			
4	هل تعطيك معتقداتك الشخصية القوة لمواجهة الصعوبات؟			
5	تشعر أنك تتحكم في حياتك؟			
6	أنت قادر على إدارة الصعوبات الشخصية؟			

	مجال الصحة البدنية			
		ابدا	احيانا	دائما
1	الألم الجسدي يمنعك من إنجاز عملك؟			
2	احتياجك للعلاجات الطبية للقيام بأنشطتك اليومية الروتينية؟			
3	هل تؤثر صعوبة الحركة على حياتك؟			
4	لديك طاقة كافية للحياة اليومية؟			
5	راض عن نومك؟			
6	راض عن قدرتك على أداء أنشطة حياتك اليومية؟			

Appendix A

7	راض عن قدرتك على العمل			
مجال الصحة النفسية				
		ابدا	احيانا	دائما
1	مامدى استمتاعك بالحياة			
2	تشعر أن حياتك ذات معنى؟			
3	ما مدى جودة قدرتك على التركيز والذاكرة؟			
4	راض عن مظهرك الخارجي؟			
	هل انت راض عن نفسك؟			
6	تعرضك الى مشاعر سلبية مثل المزاج المتقلب و اليأس و القلق أو الاكتئاب؟			
	مجال البيئة الصحية			
		ابدا	احيانا	دائما
1	البيئة التي تحيط بك صحية؟			
2	هل لديك ما يكفي من المال لتلبية احتياجاتك؟			
3	هل تتوفر المعلومات التي تحتاجها في حياتك اليومية؟			
4	هل تتاح لك الفرصة لممارسة الأنشطة الترفيهية؟			
5	شعورك بالأمان في حياتك اليومية؟			

Appendix A

6	قناعتك بظروف سكنك؟			
7	راض عن حصولك على الخدمات الصحية؟			
8	راض عن توفر وسائل النقل العامة			

مجال العلاقات الاجتماعية

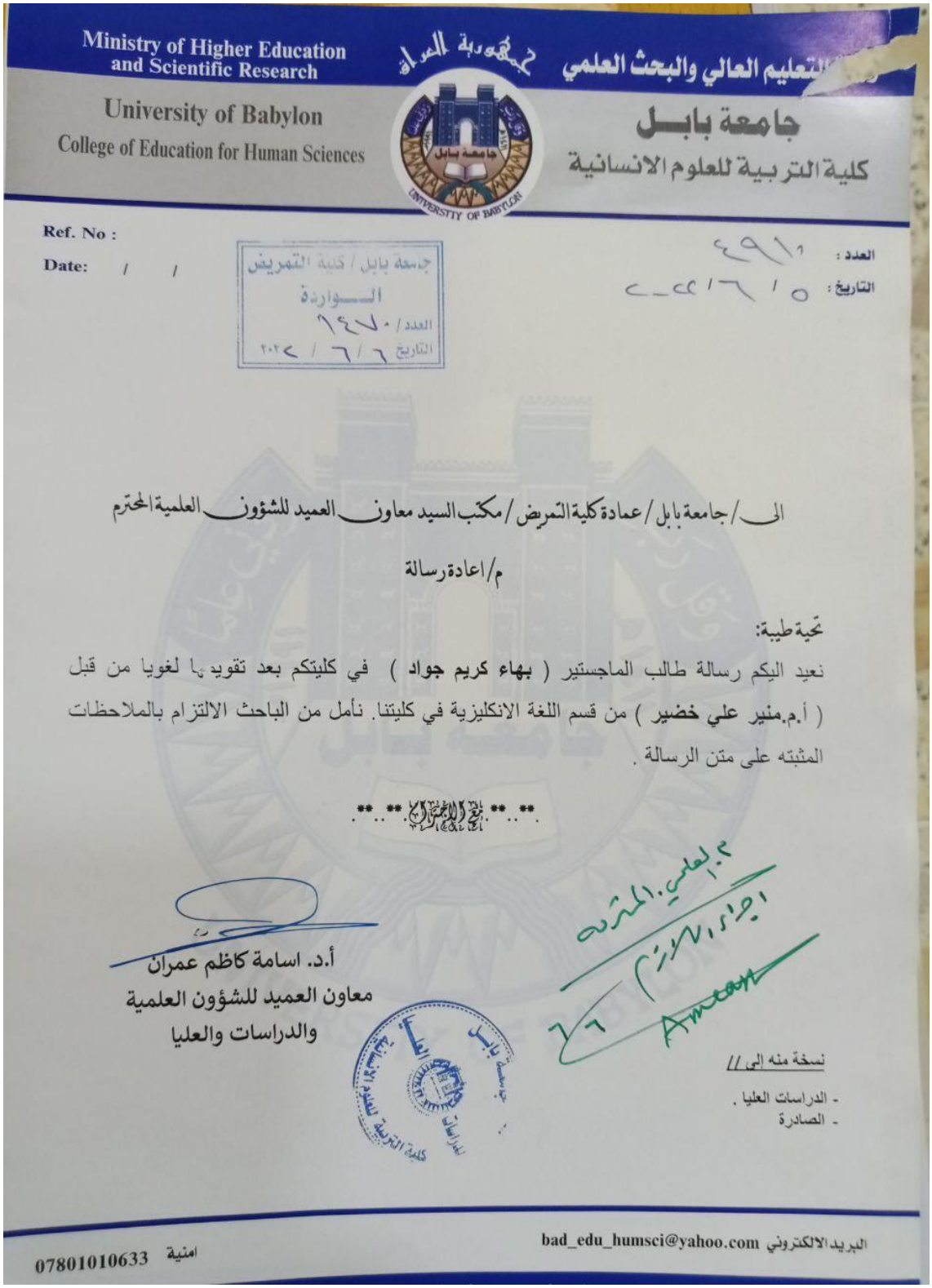
		ابدا	احيانا	دائما
1	راض عن علاقاتك الشخصية مع الاخرين؟			
2	راض عن العون الذي تلقاه من اسرتك			
3	راض عن الدعم الذي تحصل عليه من أصدقائك؟			

Appendix C

Panel of experts

		اللقب العلمي	الاختصاص	مكان العمل	سنوات الخبرة
1.	د.سلمى كاظم جهاد	استاذ	تمريض صحة المجتمع	جامعة بابل\كلية التمريض	39
2.	د.راجحة عبد الحسن حمزة	استاذ	تمريض صحة البالغين	جامعةالكوفة\كلية التمريض	38
3.	د.امين عجيل ياسر	استاذ	تمريض صحة المجتمع	جامعة بابل\كلية التمريض	37
4.	د.سلمان حسين فارس	استاذ مساعد	تمريض صحة المجتمع	جامعة كربلاء \كلية التمريض	30
5.	د.فاطمة وناس خضير	استاذ	تمريض صحة المجتمع	جامعة الكوفة\كلية التمريض	29
6.	د.شذى كاظم سعدي	استاذ مساعد	تمريض صحة البالغين	جامعة بابل\كلية التمريض	23
7.	د.وسام سعيد تاج الدين	طبيب استشاري	امراض القلب والاوعية الدموية	مركز شهيد المحراب لامراض وجراحة القلب	22
8.	د.حسام عباس داوود	استاذ مساعد	تمريض صحة البالغين	جامعة بابل\كلية التمريض	20
9.	د.شكري فائز السعد	طبيب استشاري	امراض القلب والاوعية الدموية	مركز شهيد المحراب لامراض وجراحة القلب	20
10	د.حسن عبدالله عذبي	استاذ مساعد	تمريض صحة البالغين	جامعة كربلاء \كلية التمريض	19
11	د.ابراهيم علوان كاظم	استاذ مساعد	تمريض صحة البالغين	جامعة الكوفة\كلية التمريض	16
12	د.منصور عبدالله صلاح	استاذ مساعد	تمريض صحة المجتمع	جامعة الكوفة\كلية التمريض	15
13	د.محمد عبدالكريم مصطفى	استاذ مساعد	تمريض صحة البالغين	جامعة الكوفة\كلية التمريض	14

Appendix D



Ministry of Higher Education and Scientific Research
University of Babylon
College of Education for Human Sciences

وزارة التعليم العالي والبحث العلمي
جامعة بابل
كلية التربية للعلوم الانسانية

Ref. No :
Date: / /

العدد : ٤٩١٠
التاريخ : ١٥ / ٦ / ٢٠١٧

جامعة بابل / كلية التمريض
الصادرة
العدد / ١٤٧٠
التاريخ ٦ / ٦ / ٢٠١٧

الى / جامعة بابل / عمادة كلية التمريض / مكتب السيد معاون العميد للشؤون العلمية المحترم

م/اعادة رسالة

تحية طيبة:

نعيد اليكم رسالة طالب الماجستير (**بهاء كريم جواد**) في كليتكم بعد تقويمها لغويا من قبل (أ.م.**منير علي خضير**) من قسم اللغة الانكليزية في كليتنا. نأمل من الباحث الالتزام بالملاحظات المثبته على متن الرسالة .

مع الاحترام

أ.د. اسامة كاظم عمران
معاون العميد للشؤون العلمية
والدراسات والعليا

نسخة منه الى //
- الدراسات العليا .
- الصادرة

البريد الالكتروني bad_edu_humsci@yahoo.com
امنية 07801010633

الخلاصة

المقدمة: على الرغم من التقدم الكبير في الوقاية والتشخيص والعلاج وإعادة التأهيل ، تظل أمراض القلب والأوعية الدموية واحدة من أكثر الأمراض المزمنة شيوعًا. وفقًا للإحصائيات ، فإن أمراض القلب والأوعية الدموية هي السبب الرئيسي للوفاة في جميع أنحاء العالم. يمكن أن تؤثر العديد من العوامل ، بما في ذلك الوراثة ونمط الحياة وتجنب التدخين والنشاط البدني ، على نوعية حياة كبار السن. تم ربط جودة الحياة المنخفض بزيادة خطر إعادة الدخول إلى المستشفى والوفيات في المرضى الذين يعانون من أمراض القلب والأوعية الدموية مثل قصور القلب أو أمراض القلب الإقفارية ، وكذلك الوفيات القلبية الوعائية في مجموعة متنوعة من عينات المجتمع .**أهداف الدراسة:** تهدف الدراسة إلى تقييم جودة حياة كبار السن المصابين بأمراض القلب والأوعية الدموية ومعرفة العلاقة بين البيانات الاجتماعية والديموغرافية لكبار السن المصابين بأمراض القلب والأوعية الدموية وجودة الحياة . **منهجية البحث**: تم استخدام تصميم دراسة وصفية مقطعية لفترة من 1-تشرين الاول 2022 إلى 15 -ايار-2022 ؛ أجريت الدراسة في مدينة الحلة في محافظة بابل. اختار الباحث بشكل غرضي (غير احتمالي) 120 مريضًا من كلا الجنسين من كبار السن ، تم تشخيصهم طبيًا بأمراض القلب والأوعية الدموية زاروا المستشفى وقسم الاستشاريات الخارجية. استخدم استبيان معدل لجمع البيانات من المرضى ومراعاة معايير التضمين والاستبعاد. تم تحليلها إلكترونيًا باستخدام برنامج SPSS الإصدار 26 .**النتائج:** تراوحت أعمار غالبية المرضى بين 60 - 69 سنة وشكلوا (72.5٪) من عينة الدراسة. فيما يتعلق بالجنس ، كانت معظم العينة المدروسة من الإناث.. كذلك التاريخ الطبي للعينة أظهر أن معظم الناس لديهم تاريخ من مرض الشريان التاجي ومدة المرض بأكثر من عامين مع المرض. كان غالبية الأفراد من كبار السن المصابين بأمراض القلب والأوعية الدموية ليس لديهم أي أمراض مزمنة. اوجدت الدراسة ان ان مجالات الصحة العامة، تليها الصحة الجسدية ، تليها الصحة البيئية هي الأكثر شيوعًا المرتبطة بجودة الحياة السيئة بينما جودة حياة متوسطة بالنسبة للصحة النفسية ، تسجل العلاقات الاجتماعية أعلى متوسط درجات كجودة جيدة تتعلق بالصحة الاجتماعية **الاستنتاجات والتوصيات:** استنتجت الدراسة الى ان جودة الحياة لكبار السن المصابين بأمراض القلب والأوعية الدموية (55.8٪) منهم لدية جودة حياة معتدلة.توجد فروق ذات دلالة إحصائية بين نوعية الحياة والفئات العمرية والعمل والوضع الاقتصادي وكبار السن في المناطق

الحضرية والريفية . يوصى بتطوير برامج تعليمية للرعاية الصحية التي يمكن أن تشجع على وزن صحي للجسم ، وأنشطة بدنية منتظمة لتحسين القدرة على التكيف مع حياة المريض ، والدعم النفسي والاجتماعي .

جمهورية العراق

وزارة التعليم العالي والبحث العلمي

جامعة بابل

كلية التمريض

جودة الحياة لكبار السن مع أمراض القلب والاوعية الدموية

رسالة

مقدمة الى مجلس كلية التمريض ,جامعة بابل,

كجزء من متطلبات شهادةالماجستير في علوم التمريض

تقدم بها الطالب

بهاء كريم جواد كاظم

باشراف

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